

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 16201	
1. FOR STATE REGISTRAR											
1. DECEASED NAME [TYPE OR PRINT] <b>Nellie Schuyler Achterkirchen</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> <b>6/23 19 81</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Apr. 5, 1900</b>		6. AGE (IN YEARS) LAST BIRTHDAY YRS. <b>81</b>		7c. DATE PRONOUNCED DEAD <b>6/23 19 81</b>		2b. HOUR <b>8:40 A. M.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wash., D.C.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD.</b>	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION [IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS] <b>8000 Glenside Drive</b>				12a. USUAL OCCUPATION [TYPE OF WORK FOR MOST OF WORKING LIFE] <b>Ret.-Admin. Ass't.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Dairy</b>	
13a. STATE <b>Maryland</b>				13b. CITY OR TOWN <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>8000 Glenside Drive</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Alexander Bruce Schuyler</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Josephine Emma Gudgin</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? [YES, NO, OR UNKNOWN] <b>No</b>				16b. SOCIAL SECURITY NO. <b>577-03-6686</b>		17. INFORMANT <b>Edna J. Rich, Arlington, Virginia 22203</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial disease</b> 4029 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>hypertensive heart disease.</b> (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <b>None</b>											
19a. DATE OF OPERATION <b>None</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>None</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY [AT HOME, STREET, FACTORY, FARM, ETC.]		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>John S. Rogers, M.D.</b>				TITLE (SPECIFY) <b>Deputy</b>				MEDICAL EXAMINER			
EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers, M.D.</b>				ADDRESS <b>1919 Seminary Road Silver Spring, Montgomery, Md.</b>				DATE SIGNED <b>6/23/81</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>6/25/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, Maryland</b>	
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b>						25. REGISTRATION DATE <b>JUN 30 1981</b>					
NAME <b>5130 Wisconsin Ave., NW, Washington, D.C. 20016</b>						ADDRESS					



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
ESKEL				ADAMS	June 20, 1981				1:40am	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS			
MALE	CAUCASIAN	10/17/95		85	MONTHS		DAYS		HOURS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
KENTUCKY	U.S.A.			Montgomery MD.						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Olney	Montgomery General Hospital			SALESMAN R.J.		REYNOLDS TOB.CO.				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?				
MARYLAND	MONTGOMERY		WHEATON		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)						
COVY		DELIA LARGE		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
				243-10-0619		ESKELINE A. JONES DAUGHTER SAME AS 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>chronic congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerotic heart disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Ten days</u> <u>3 months</u> <u>20 yrs.</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>cerebro vascular accident &amp; subacute renal failure.</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>6/1/81</u> 19 <u>81</u> to <u>6/20/81</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>6/19/81</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>g maltz</u> MD.			22c. DATE SIGNED <u>6/20/81</u>			22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>JONATHAN MALTZ</u>		
22e. ADDRESS <u>18111 Prince Philip Drive, Olney, Maryland 20832</u>		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>			23b. DATE <u>6/24/81</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GREENLAWN CEMETERY</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>LOUISA LAWRENCE KENTUCKY</u>	
24. FUNERAL DIRECTOR NAME <u>FRANCIS J. COLLINS</u> ADDRESS <u>500 UNIV BLVD.W., SILVER SPRING, MD. 20901</u>				25a. DATE REC'D. BY REGISTRAR <u>JUN 22 1981</u>		25b. REGISTRAR'S SIGNATURE <u>Pistay Mabury</u>				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained for 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 6 2 0 3

FOR  
STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Lillian Roby Aitcheson			2a DATE OF DEATH MONTH DAY YEAR June 30, 1981			2b HOUR 8PM M				
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Oct. 26, 1899		6 AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10 CITY OR TOWN OF DEATH Burtonsville		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4700 Sandy Spring Road				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b KIND OF BUSINESS OR INDUSTRY home		
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md			13b COUNTY Montgomery		13c CITY OR TOWN Burtonsville		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS 4700 Sandy Spring Road	
14 FATHER'S NAME FIRST MIDDLE LAST Marcellus Roby				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Maude Parker						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT ADDRESS Joseph L. Aitcheson, Sr same as above				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Chronic Coronary Artery Disease</u> (c) <u>Due to, or as a consequence of</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8-10 Mo 9-10 Mo		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22 I certify that (I) (this hospital) attended the deceased from <u>January 81</u> 19 <u>81</u> to <u>June 30</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>June 30</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22a SIGNATURE <u>Robert C. Wingfield, MD</u>						DEGREE MD		22c DATE SIGNED <u>July 2, 1981</u>		
22b PHYSICIAN'S NAME (TYPE OR PRINT) <u>Robert C. Wingfield</u>						22d ADDRESS <u>229 Prince Georges St. Laurel, Md.</u>				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE July 3, 1981		23c NAME OF CEMETERY OR CREMATORY Union Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Burtonsville, Md			
24 FUNERAL DIRECTOR NAME Donaldson Funeral Home, Laurel, Md						25a DATE REC'D. BY REGISTRAR JUL 5 1981		25b REGISTRAR'S SIGNATURE <u>James J. [Signature]</u>		

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Journal of Management Education 30(1)

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 16204	
1- FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RUSSELL R. ALAWINE										2b. HOUR 8:00 PM	
2. SEX Male		4. RACE White		3. DATE OF BIRTH MONTH DAY YEAR Oct. 11, 1956		6. AGE (IN YEARS LAST BIRTHDAY) 24 YRS.		5. IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD June 14, 1981	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD	
10. CITY OR TOWN OF DEATH BETHESDA				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Construction	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Wheaton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4401 Randolph Rd.			
14. FATHER'S NAME FIRST MIDDLE LAST Alton J. Alawine						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruth J. Hanson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 215-72-7261		17. INFORMANT ADDRESS Ruth J. Hanson (Apt. 102) 28 W. Deerpark Rd. Gaithersburg, Md. 20760					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8169 IMMEDIATE CAUSE (a) <u>Closed Head Brain Death.</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Closed Head Trauma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Motor Cycle Accident.</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR AM. MONTH DAY YEAR 8 P.M. 6 14 1981		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Lost control of motor cycle had injury					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Street		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Randolph Rd. Wheaton Mont. Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John G. Ball				TITLE (SPECIFY) M.D. Deputy				DATE SIGNED June 15, 1981			
EXAMINER'S NAME (TYPE OR PRINT) John G. Ball, M.D.				ADDRESS 7936 Old Georgetown Rd., Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/20/81		23c. NAME OF CEMETERY OR CREMATORY Prospect Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Meridian Lauderdale Miss.			
24. FUNERAL DIRECTOR Gartner Sandison F.H. Gaithersburg, Md. 20760						25a. DATE REC'D. BY REGISTRAR JUN 22 1981		25b. REGISTRAR'S SIGNATURE [Signature]			

RECEIVED  
FEB 14 1964



TO: DIRECTOR, FBI  
FROM: SAC, NEW YORK  
SUBJECT: [illegible]

RE: [illegible]  
[illegible]  
[illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					8 1 1 6 2 0 5				
1- FOR STATE REGISTRAR					CERTIFICATE OF DEATH				
1 DECEASED NAME (TYPE OR PRINT)					2a DATE OF DEATH				
FIRST MIDDLE LAST					MONTH DAY YEAR				
Loma O. Allen, Sr.					June 12 1981				
3 SEX					7b HOUR				
male					9 A M				
4 RACE					5 DATE OF BIRTH				
caucasian					MONTH DAY YEAR				
Oct. 23 1899					6 AGE (IN YEARS LAST BIRTHDAY)				
81 YRS.					7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)				
North Carolina					7b CITIZEN OF WHAT COUNTRY?				
U.S.A.					8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				
10 CITY OR TOWN OF DEATH					9 BALTIMORE CITY OR COUNTY OF DEATH				
Wheaton					Montgomery MD.				
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				
11312 Galt Avenue					Machinist				
12b KIND OF BUSINESS OR INDUSTRY					13a STREET ADDRESS				
Navy Yard					11312 Galt Avenue				
13a STREET ADDRESS					13b. INSIDE CITY LIMITS?				
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13c. CITY OR TOWN				
13d. COUNTY					13e. STATE				
Montgomery					Maryland				
14 FATHER'S NAME					15 MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST					FIRST MIDDLE LAST				
Christopher C. Allen					Eva Croom				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b SOCIAL SECURITY NO.				
No					578-38-6962				
17 INFORMANT					ADDRESS				
Myrtle E. Allen Wife					Same as 13				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b). Coronary Artery disease 3 years DUE TO, OR AS A CONSEQUENCE OF (c). Arteriosclerotic Heart disease 5 years					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Nodular Lymphoma									
19a DATE OF OPERATION					19b CONDITION FOR WHICH OPERATION WAS PERFORMED				
20a AUTOPSY?					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY				
					HOUR A.M. MONTH DAY YEAR				
					P.M. 19				
21d. INJURY OCCURRED					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK					21f. LOCATION				
					STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (this hospital) attended the deceased from 4-25-81 to 6-12-81, that (II) (we) last saw the deceased alive on 6-8-81, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.					22b. SIGNATURE				
					DEGREE				
					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
22c. PHYSICIAN'S NAME (TYPE OR PRINT)					22d. ADDRESS				
Morris Perry					11602 Georgia Ave. Silver Spring, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)					23b. DATE				
Burial					Jun. 15, 1981				
23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION				
Fort Lincoln Cemetery					Brentwood Pr. Geo. Md.				
24 FUNERAL DIRECTOR NAME					25a. DATE REC'D. BY REGISTRAR				
Francis J. Collins					JUN 15 1981				
500 University Blvd., W. Silver Spring, Md.					25b. REGISTRAR'S SIGNATURE				
					[Signature]				



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATHFOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Baby Boy Alston			2a. DATE OF DEATH MONTH DAY YEAR May 19 1981			2b. HOUR 11:09 AM			
3. SEX male		4. RACE black		5. DATE OF BIRTH MONTH DAY YEAR May 19 1981		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 1		7. IF UNDER 1 YEAR IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mont., Md.		7b. CITIZEN OF WHAT COUNTRY? yes		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Mont. MD.			
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Mont.		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS 11215 Oakleaf Dr. #1011	
14. FATHER'S NAME FIRST MIDDLE LAST Rudolph Henry Alston				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carol Michelle Bradley					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Prématurité</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Premature rupture of membrane</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Carol N. Paulino MD</i>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) cremation			23b. DATE 5-27-81		23c. NAME OF CEMETERY OR CREMATORY Washington Adventist		23d. LOCATION CITY OR TOWN COUNTY STATE Takoma Park, Mont. Md.		
24. FUNERAL DIRECTOR NAME Dr. H. Shiroma, 7600 Carroll Ave., Tk. Pk., Md.						25a. DATE REC'D. BY REGISTRAR JUN 23 1981		25b. SIGNATURE <i>Robert M. Bradley</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 6 2 0 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) George G. Armstrong			2a. DATE OF DEATH June 10 81		2b. HOUR 12:21 PM
3. SEX Male	4. RACE white	5. DATE OF BIRTH 9 23 1886	6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Nova Scotia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH x <del>Retired</del> Montgomery MD.		
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Engineer	
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Kensington	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 5029 White Flint Drive,
14. FATHER'S NAME FIRST MIDDLE LAST unknown Armstrong		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 023-03-2423A		17. INFORMANT ADDRESS Pearl Dodds-daughter-(same as 13e)	

18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction 2500 DUE TO, OR AS A CONSEQUENCE OF (b) diabetes mellitus DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerotic vascular disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Two days	
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) <del>the hospital</del> attended the deceased from 9 June 1981, to 10 June 1981, that (I) <del>last</del> saw the deceased alive on 9 June 1981, and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did) <del>not</del> view the body after death.			
22b. SIGNATURE Walter E. Gooch MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 10 June 81
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALTER E. GOOCH MD		22e. ADDRESS 2309 SHOREFIELD RD WHEATON MD	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 6-11-1981	23c. NAME OF CEMETERY OR CREMATORY Metropolitan	23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria-Alexandria Va.
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. 8434 Georgia Ave., S.S. Md.		25a. DATE REC'D. BY REGISTRAR JUN 15 1981	25b. REGISTRAR'S SIGNATURE Ruthy H. Bandy



and my dear friend  
the day  
of the  
and my dear friend

Wm. J. L. L. L.

Wm. J. L. L. L.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8116208		
1. FOR STATE REGISTRAR										2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR
1. DECEASED NAME FIRST MIDDLE LAST MORRIS DAVID ARONSON										6-25-81		9:30 A M
3. SEX Male		4. RACE WHITE		5. DATE OF BIRTH FEB. 01 21		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN) WASHINGTON, DC		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD			10. KIND OF BUSINESS OR INDUSTRY LIBRARIES			
10. CITY OR TOWN OF DEATH Silver Spring, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION NOT IN SUCH FACILITY, GIVE STREET ADDRESS Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECURITY		12b. KIND OF BUSINESS OR INDUSTRY LIBRARIES				
13a. STATE MARYLAND		13b. COUNTY PRINCE GEORGE		13c. CITY OR TOWN ADELPHI		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9250 EDWARDS WAY #411				
14. FATHER'S NAME FIRST MIDDLE LAST PHILIP ARONSON				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DORA MALLINOFF								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII 579-18-7334		17. INFORMANT ADDRESS SHIRLEY B. ARONSON, same as #13						
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC ADENOCARCINOMA OF STOMACH 1519 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 mos		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (the hospital) attended the deceased from MAY 25, 1980, to JUNE 24, 1981, that (I) (we) lost the deceased on JUNE 24, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. PHYSICIAN'S SIGNATURE James G. Brown				DEGREE				22c. DATE SIGNED 6/25/81				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES A. BROWN, MD				22e. ADDRESS 625 BELCREST RD HYATTSVILLE, MD 20782								
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 6/26/1981		23c. NAME OF CEMETERY OR CREMATORY MOUNT LEBANON CEMETERY		23d. LOCATION ADELPHI, PR. GEORGES,		STATE				
24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.						25a. DATE REC'D. BY REGISTRAR JUN 29 1981		25b. REGISTRAR'S SIGNATURE Maryland				



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 1 16209	
1. DECEASED NAME (TYPE OR PRINT) <b>Harold NMI Ballou</b>						2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH DAY YEAR <input checked="" type="checkbox"/> <b>June 28, 81</b>		2b. HOUR <b>A</b>			
3. SEX <b>Male</b>		4. RACE <b>Cauc.</b>		5. DATE OF BIRTH <b>October 31, 1898</b>		6. AGE (IN YEARS) <b>82</b> YRS.		7. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD <b>June 30, 1981</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Rhode Island</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County, MD.</b>		10. CITY OR TOWN OF DEATH <b>Chevy Chase</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>8909 Connecticut Avenue</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Administrative</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt.</b>		13a. STREET ADDRESS <b>8909 Connecticut Avenue</b>		13b. CITY OR TOWN <b>Montgomery</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>Maryland</b>	
14. FATHER'S NAME <b>Not Available</b>		15. MOTHER'S MAIDEN NAME <b>Louise Udall</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Not Available</b>		16b. SOCIAL SECURITY NO. <b>220-40-7493</b>		17. INFORMANT <b>George Ballou (Son)</b>		17. ADDRESS <b>242 West 16th St. New York, New York</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Insufficiency</b> 4110 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <b>Cardio Vascular Disease</b> (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>John G. Ball</b>				TITLE (SPECIFY) <b>M.D. Deputy</b>				DATE SIGNED <b>June 30, 1981</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>John G. Ball, M.D.</b>				ADDRESS <b>7936 Old Georgetown Rd, Bethesda</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>				23b. DATE <b>July 2, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan Crem.</b>			23d. LOCATION CITY OR TOWN <b>Alexandria, Virginia</b> COUNTY <b>MD.</b> STATE		
24. FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland 20814</b>						25a. DATE REC'D. BY REGISTRAR <b>JUL 9 1981</b> REGISTRAR'S SIGNATURE <b>James J. Martin</b>					

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Rose Banerian					2a. DATE OF DEATH MONTH DAY YEAR June 3, 1981			2b. HOUR 10:30PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 28 1897		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Armenia (Turkey)		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. INDUSTRY OF BUSINESS OR INDUSTRY	
13a. STATE D.C.		13b. COUNTY Washington		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1431 Rittenhouse St., N.W.	
14. FATHER'S NAME FIRST MIDDLE LAST Unobtainable					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unobtainable				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-56-7906		17. INFORMANT ADDRESS Ben Irvin/Atty. 1130 Harding Lane Silver Spring, Md. 20904					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Operation of gun</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCD</u> DUE TO, OR AS A CONSEQUENCE OF (c) 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 8/12 1980 to 6/3 81, that (I/we) last saw the deceased alive on 6/3 81, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I/we) (did not) view the body after death.									
22b. SIGNATURE Myron L. Lenkin		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/4/81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MYRON L. LENKIN		22e. ADDRESS 2309 SHOREFIELD RD WHITEHORN MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-8-81		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem		23d. LOCATION CITY OR TOWN Brentwood		23e. COUNTY, STATE B. Georges Md.	
24. FUNERAL DIRECTOR NAME Hines/Rinaldi F.H.		11800 New Hampshire Ave. Silver Spring, Md. 20904		25a. DATE REC'D BY REGISTRAR JUN 9 1981					

MEDICAL CERTIFICATION

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Yonkers

Albany

Albany (Knox)

U.S.A.

Honorable

Washington

Washington

1431 Wisconsin St. N.W.

Unobtainable

Unobtainable

EX-10-10

1133 Lexington Lane

1133 Lexington Lane

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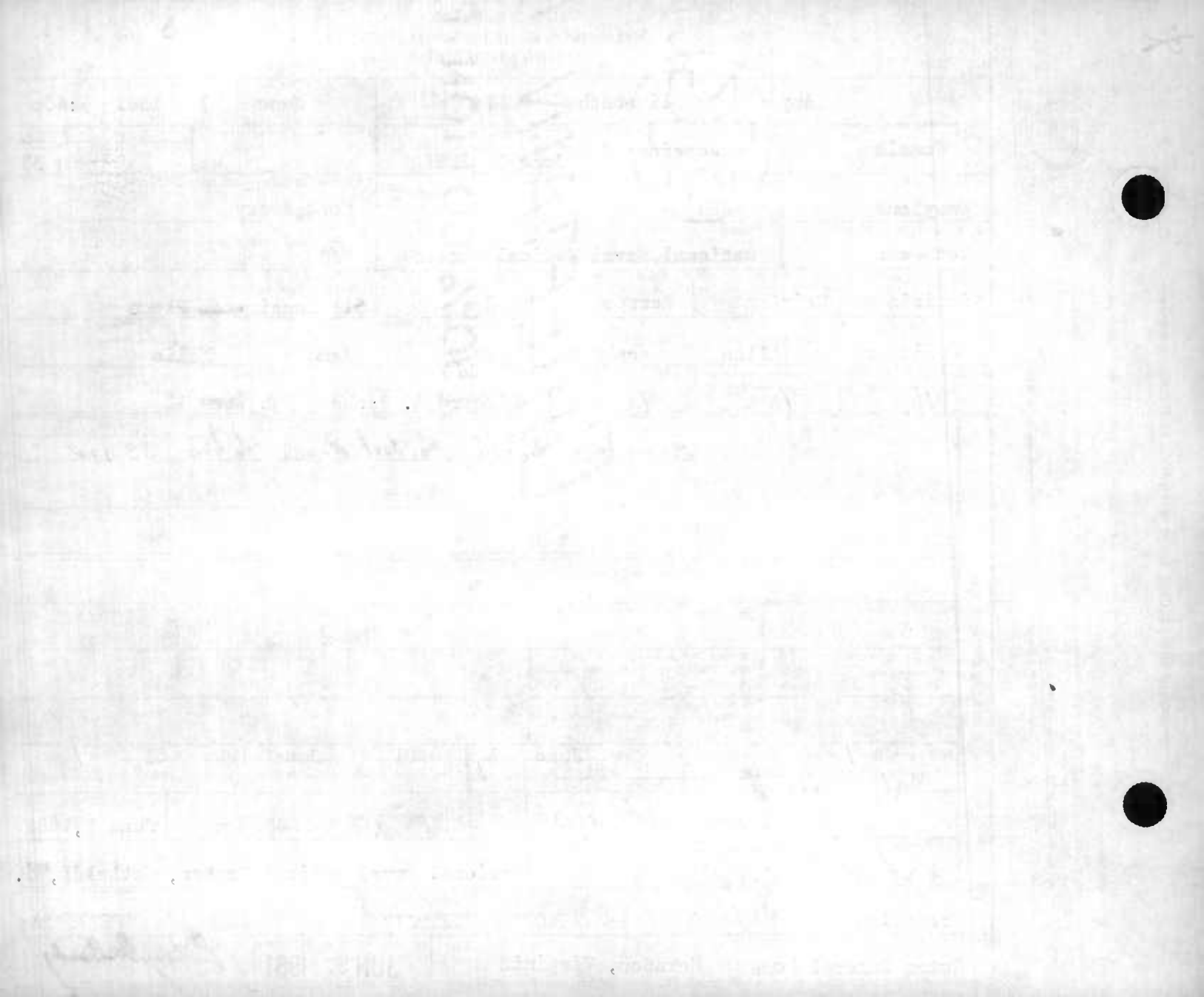
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
CERTIFICATE OF DEATH										
REG. NO.										
1. FOR STATE REGISTRAR					2a. DATE OF DEATH MONTH DAY YEAR					2b. HOUR
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Amy Elizabeth BANKS					June 1 1981					9:45p <sup>AM</sup>
3 SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR June 1 1981		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 33		IF UNDER 1 YEAR IF UNDER 24 HRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD				
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Virginia					13b. CITY OR TOWN Herndon		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13d. STREET ADDRESS 511 Kensington Place
14. FATHER'S NAME FIRST MIDDLE LAST Richard Allen Banks					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nancy Jane Melia					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A			16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS Richard A. Banks See item 13					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 7708 IMMEDIATE CAUSE (a) <u>Premature Birth, Failed Resuscitation</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>33 MIN</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE					
22a. I certify that I (this hospital) attended the deceased from <u>June 1</u> , 19 <u>81</u> , to <u>June 1</u> , 19 <u>81</u> , that I (we) last saw the deceased alive on <u>June 1</u> , 19 <u>81</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>D. F. Wright MD</u>					DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED June 3, 1981	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>D. F. Wright</u>					22e. ADDRESS National Naval Medical Center, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 6/4/81		23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA VIRGINIA			
24. FUNERAL DIRECTOR NAME Green Funeral Home					ADDRESS Herndon, Virginia		25a. DATE REC'D. BY REGISTRAR JUN 9 1981		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



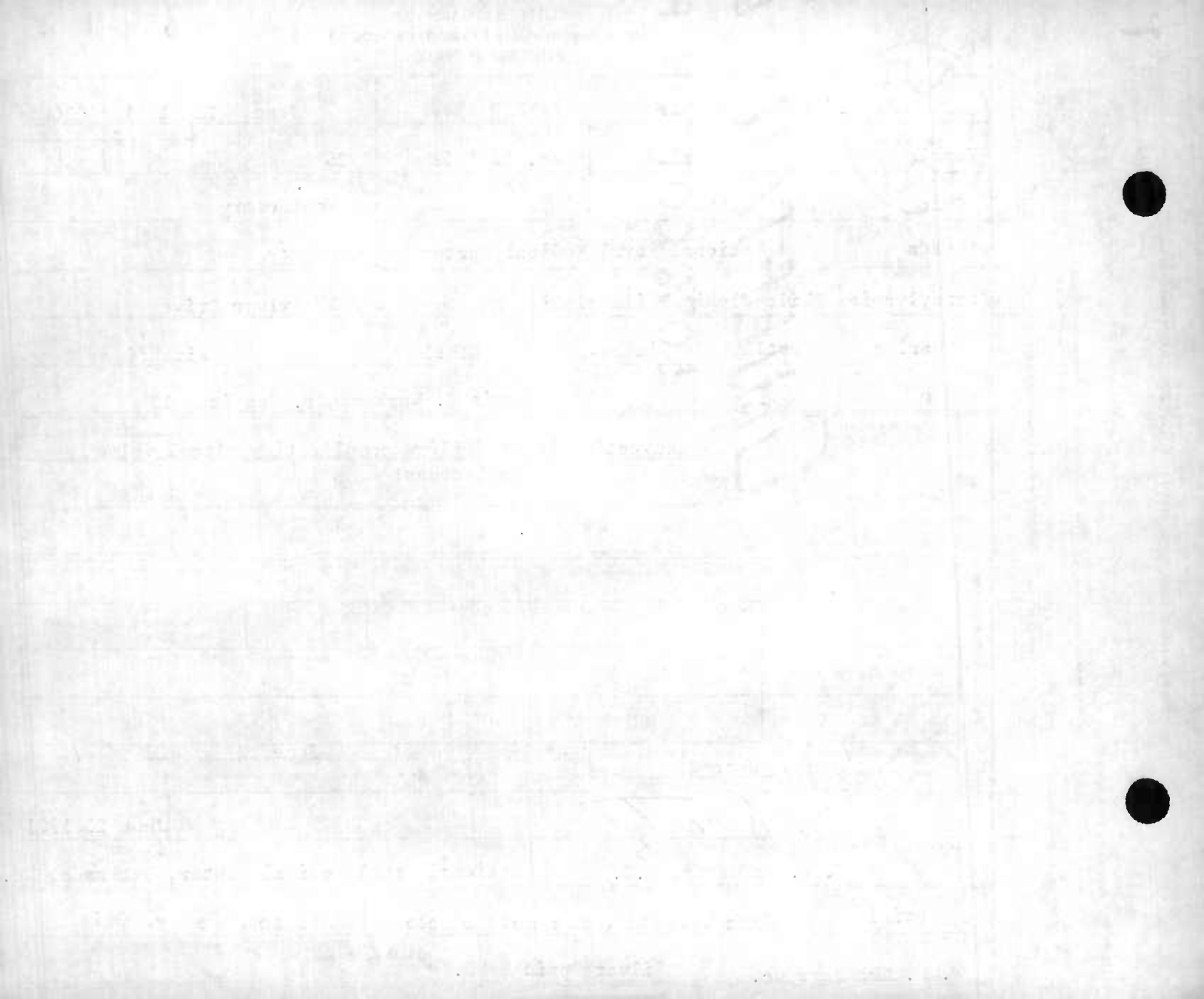
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					8 1 1 6 2 1 2	
1 - FOR STATE REGISTRAR					CERTIFICATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH	
Linda Mae BARKER					June 22 1981	
3. SEX		4. RACE		5. DATE OF BIRTH		
Female		Caucasian		Dec. 22 1952		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		6. AGE (IN YEARS LAST BIRTHDAY)		
Ohio		USA		28 YRS.		
10. CITY OR TOWN OF DEATH				9. BALTIMORE CITY OR COUNTY OF DEATH		
Bethesda				Montgomery MD.		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
National Naval Medical Center				Housewife		
13a. STATE				13b. CITY OR TOWN		
Pennsylvania				Philadelphia		
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME		
Charles Westley Wickham				Ethel Kirkbride		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		
No				Unk		
17. INFORMANT				ADDRESS		
Lewis E. Barker, Jr.				See item 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure complicating mitral valve replacement</u> 3949 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I (this hospital) attended the deceased from <u>June 14</u> , 19 <u>81</u> , to <u>June 22</u> , 19 <u>81</u> , that (I (we) lost saw the deceased alive on <u>June 22</u> , 19 <u>81</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I (we) (did) (did not) view the body after death.						
22b. SIGNATURE				22c. DATE SIGNED		
<i>J. E. Schwartz</i>				June 23 1981		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS		
J. E. Schwartz, M.D.				National Naval Medical Center, Bethesda, Md.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		
Burial		June 25, 1981		Somerset Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE RECEIVED BY REGISTRAR				
Somerset, Perry, Ohio		JUN 24 1981				
24. FUNERAL DIRECTOR NAME				25. REGISTRAR'S SIGNATURE		
W. W. Chambers Co.				<i>[Signature]</i>		
ADDRESS				26. REGISTRAR'S SIGNATURE		
Silver Spring, Md.				<i>[Signature]</i>		



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- STATE REGISTRAR		STATE OF MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH		1 6 2 1 3	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE KNOWN OF DEATH		2b. DATE OF ESTI- MATED	
BRENDA		20. DATE KNOWN OF DEATH		2b. DATE OF ESTI- MATED	
2. SEX		3. RACE		4. DATE OF BIRTH	
female		White		Nov. 25, 1961	
5. BIRTHPLACE (STATE OR COUNTY)		6. CITIZEN OF WHAT COUNTRY?		7. MARRIED	
New Jersey		U.S.A.		X	
8. CITY OR TOWN OF DEATH		9. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		10. USUAL OCCUPATION (TYPE OF WORK FOR MAINT. OR WORKING LIFE)	
Potomac		Potomac River Near Angler's Inn		None	
11. STATE		12. CITY OR TOWN		13. STREET ADDRESS	
Md.		Montgomery		9320 19th Ave. Apt. 201	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES?	
James		Phyllis		No	
17. SOCIAL SECURITY NO.		18. INFORMANT		19. ADDRESS	
N/A		James Barley (Father)		Brick Twsp. N.J.	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		21. IMMEDIATE CAUSE (a)		22. DUE TO, OR AS A CONSEQUENCE OF	
Drowning		Drowning		DUE TO, OR AS A CONSEQUENCE OF	
9102		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		23. DATE OF OPERATION		24. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
25. EXTERNAL CAUSE WAS		26. TIME OF INJURY		27. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		5:00PM 6/7 1981		drown while swimming in river	
28. INJURY OCCURRED		29. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		30. LOCATION	
WHILE AT WORK NOT WHILE AT WORK		river		CatFishHole, PotomacRiver, Montgomery Co, MD	
31. I certify that I took charge of the remains described above, held an autopsy		32. Inspection		33. Inquiry	
death resulted from: Natural causes Accident Suicide		Inspection		Inquiry	
H. Guard		TITLE (SPECIFY)		DATE	
M.D. Assistant		MEDICAL EXAMINER		6/12/81	
34. EXAMINER'S NAME (TYPE OR PRINT)		35. ADDRESS		36. DATE REC'D. BY REGISTRAR	
Hormez R. Guard, M.D.		111 Penn Street, Baltimore, MD 21201		JUN 16 1981	
37. BURIAL, CREMATION, REMOVAL (SPECIFY)		38. DATE		39. NAME OF CEMETERY OR CREMATORY	
Burial		6/16/81		St. Mary's Cemetery Lakewood Ocean N.J.	
40. FUNERAL DIRECTOR NAME		41. ADDRESS		42. DATE REC'D. BY REGISTRAR	
Fleming Barnes		Funeral Service - Benson, Md.		JUN 16 1981	



RECEIVED  
JUN 1 1981

JUN 1 1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

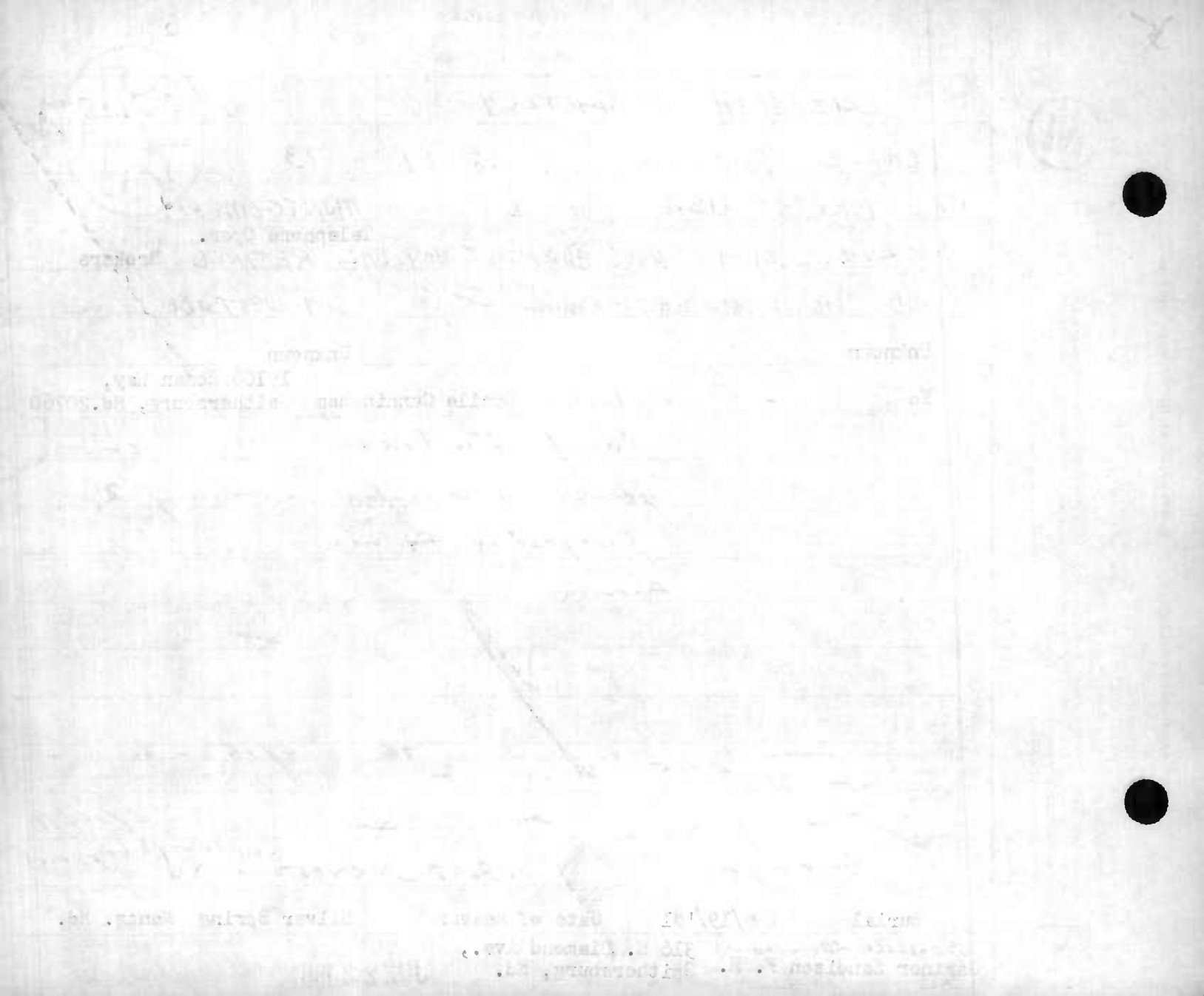
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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 6 2 1 4			
FOR 1 - STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>ELIZABETH C. BARTLEY</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>6 15 81</b>			
3 SEX <b>FEMALE</b>		4 RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 18 07</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.	
10 CITY OR TOWN OF DEATH <b>ROCKVILLE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SHADY GROVE ADVENTIST HOSPITAL RETIRED</b>				12a. TYPE OF BUSINESS OR INDUSTRY <b>Brokers</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>MD.</b> 13b COUNTY <b>MONTGOM.</b> 13c CITY OR TOWN <b>GAITHERSBURG</b> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <b>301 WESTSIDE DRIVE</b>							
14 FATHER'S NAME FIRST MIDDLE LAST <b>Unknown</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>060072042</b>		17 INFORMANT <b>19108 Roman Way, Cecile Cunningham Gaithersburg, Md. 20760</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Renal Failure</b> <b>4280</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>generalized vascular insufficiency 2 yrs</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Congestive failure</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 mo</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Anemia</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) <b>(the hospital)</b> attended the deceased from <b>6/15</b> , 19 <b>81</b> , to <b>6/15</b> , 19 <b>81</b> , that (I) <b>(we)</b> last saw the deceased alive on <b>6/15</b> , 19 <b>81</b> , and that in (my) <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above, (I) <b>(we)</b> <b>(did not)</b> view the body after death.							
22b. SIGNATURE <b>[Signature]</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>6/15/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Greger</b>				22e. ADDRESS <b>12105 Oakcrest Rd Gaithersburg, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/19/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring Montg. Md.</b>	
24. FUNERAL DIRECTOR <b>Gartner Sandison F. H.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 22 1981</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 6 2 1 5			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
BERTHA BASSLER				June 28, 1981				7:08p			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS.	
F		White		Dec. 6, 1905		75		MONTHS		DAYS	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Maryland		Olney		Montgomery General Hospital		domestic		housework			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Md		Montgomery		Burtonsville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		14408 Old Columbia Pike			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
John G. Bassler				Dora Dieker							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
no				214 42 2843		Ethel Miles same as above					
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <i>Cardiac Shock</i>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) <i>Acute infarct wall M.I. - extension</i>											
(c) <i>Hypertension C.V. Disease</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
6/17/81				<i>Cholecystectomy - cholecystitis</i>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
				HOUR A.M. MONTH DAY YEAR							
21d. INJURY OCCURRED				21e. PLACE OF INJURY				21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				STREET CITY OR TOWN COUNTY STATE			
								65 6/28 81			
22a. I certify that (I) (this hospital) attended the deceased from <i>6/28</i> 19 <i>81</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
<i>[Signature]</i>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				6/29/81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
<i>C. H. L. [Signature]</i>				1811 P. P. Highway, Olney, Md 20832							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial				July 1, 1981		St Pauls Lutheran Cem		Fulton, Maryland			
24. FUNERAL DIRECTOR NAME											
Donaldson Funeral Home, Laurel, Maryland											

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Journal of Management Education 30(1)

NO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8116216		
FOR STATE REGISTRAR					CERTIFICATE OF DEATH					REG. NO.		
1. DECEASED NAME (TYPE OR PRINT) <b>EDWARD B. BEALE</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>6 4 81</b>					2b. HOUR <b>2:30 PM</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 1, 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY CT MD.</b>						
10. CITY OR TOWN OF DEATH <b>BETHESDA, MD.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SUBURBAN HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Patent Attorney</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Self-Employed</b>				
13a. STATE <b>Maryland</b>					13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Potomac</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>10617 Red Barn Lane</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frederick W. Beale</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Jeannett - Lane</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>W.W. II</b>		17. INFORMANT ADDRESS <b>Ruth E. Beale-Address same as #13 above.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiogenic Shock</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Coronary Arteriosclerosis</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>9 days</b> <b>9 days</b> <b>20 yrs</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Emphysema, Chronic Bronchitis</b>												
19a. DATE OF OPERATION <b>4/10/81</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>1976</b> to <b>June 4</b> 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>June 4</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>G. Stuart Scott</b>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED <b>6/4/81</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>G. Stuart Scott</b>					22e. ADDRESS <b>10401 Old Georgetown Rd Bethesda Md 20014</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>6/5/1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, Maryland</b>				
24. FUNERAL DIRECTOR NAME ADDRESS <b>Joseph Gawler's Sons 5130 Wisc. Ave., N.W. Wash., D.C.</b>					25a. DATE REC'D. BY REGISTRAR <b>JUN 10 1981</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

MEDICAL CERTIFICATION

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## CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Ruth Koester Beecroft</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6/25/81</b>			2b. HOUR <b>9 05 PM</b>		
3. SEX <b>F</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>12 8 03</b>		6. AGE IN YEARS (LAST BIRTHDAY) <b>77</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Missis.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Carriage Hill Nursing Center</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Doctor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Medical</b>	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Chevy Chase</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>(unknown) Koester</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Essie Gilbert</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>213-46-5818</b>		17. INFORMANT (Guardian) ADDRESS <b>S.S. John Campbell-520 Ashford Rd. Md.</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4140 Congestive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Pneumonia</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>None</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>None</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>None</b>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NO WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>None</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>None</b>				
22a. I certify that (I) (this hospital) attended the deceased from <b>April 1981</b> to <b>present</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>6/24</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>John B. Umkehr</b>				DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>6/25/81</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John B. Umkehr</b>				22e. ADDRESS <b>8805 Conn Ave., Chevy Chase</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>6-26-1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Alexandria Alexandria Md.</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>Warner E. Pumphrey, Inc. 8434 Ga. Ave., S.S. Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 30 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Robert H. Harty</b>		

Beacroft

Ruth

Montgomery County

Silver Spring Cottage Hill Nursing Center

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in advance.

FOR  
1. STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 6 2 1 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ALICE Valli BERARDI</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6 9 81</b>		2b. HOUR <b>12<sup>40</sup> AM</b>
3. SEX <b>female</b>	4. RACE <b>white</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>2 23 96</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Italy</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>
13a. STATE <b>MD</b>		13b. COUNTY <b>Mont</b>	13c. CITY OR TOWN <b>Bethesda</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Vincent Valli</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lucia Gori</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>204 Dowlin Avenue, Paul Lesako Funeral Home-Carmichaels,</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Concussion Myocardial Infarction</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Anteroseptal Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>8 years</b>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>PA</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) <b>this hospital</b> attended the deceased from <b>6/9/81</b> to <b>6/9/81</b> , that (1) <b>no</b> last saw the deceased alive on <b>6/9/81</b> , and that in (my) <b>own</b> opinion death occurred on the date and hour and from the causes stated above (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z) (aa) (ab) (ac) (ad) (ae) (af) (ag) (ah) (ai) (aj) (ak) (al) (am) (an) (ao) (ap) (aq) (ar) (as) (at) (au) (av) (aw) (ax) (ay) (az) (ba) (bb) (bc) (bd) (be) (bf) (bg) (bh) (bi) (bj) (bk) (bl) (bm) (bn) (bo) (bp) (bq) (br) (bs) (bt) (bu) (bv) (bw) (bx) (by) (bz) (ca) (cb) (cc) (cd) (ce) (cf) (cg) (ch) (ci) (cj) (ck) (cl) (cm) (cn) (co) (cp) (cq) (cr) (cs) (ct) (cu) (cv) (cw) (cx) (cy) (cz) (da) (db) (dc) (dd) (de) (df) (dg) (dh) (di) (dj) (dk) (dl) (dm) (dn) (do) (dp) (dq) (dr) (ds) (dt) (du) (dv) (dw) (dx) (dy) (dz) (ea) (eb) (ec) (ed) (ee) (ef) (eg) (eh) (ei) (ej) (ek) (el) (em) (en) (eo) (ep) (eq) (er) (es) (et) (eu) (ev) (ew) (ex) (ey) (ez) (fa) (fb) (fc) (fd) (fe) (ff) (fg) (fh) (fi) (fj) (fk) (fl) (fm) (fn) (fo) (fp) (fq) (fr) (fs) (ft) (fu) (fv) (fw) (fx) (fy) (fz) (ga) (gb) (gc) (gd) (ge) (gf) (gg) (gh) (gi) (gj) (gk) (gl) (gm) (gn) (go) (gp) (gq) (gr) (gs) (gt) (gu) (gv) (gw) (gx) (gy) (gz) (ha) (hb) (hc) (hd) (he) (hf) (hg) (hh) (hi) (hj) (hk) (hl) (hm) (hn) (ho) (hp) (hq) (hr) (hs) (ht) (hu) (hv) (hw) (hx) (hy) (hz) (ia) (ib) (ic) (id) (ie) (if) (ig) (ih) (ii) (ij) (ik) (il) (im) (in) (io) (ip) (iq) (ir) (is) (it) (iu) (iv) (iw) (ix) (iy) (iz) (ja) (jb) (jc) (jd) (je) (jf) (jg) (jh) (ji) (jj) (jk) (jl) (jm) (jn) (jo) (jp) (jq) (jr) (js) (jt) (ju) (jv) (jw) (jx) (jy) (jz) (ka) (kb) (kc) (kd) (ke) (kf) (kg) (kh) (ki) (kj) (kk) (kl) (km) (kn) (ko) (kp) (kq) (kr) (ks) (kt) (ku) (kv) (kw) (kx) (ky) (kz) (la) (lb) (lc) (ld) (le) (lf) (lg) (lh) (li) (lj) (lk) (ll) (lm) (ln) (lo) (lp) (lq) (lr) (ls) (lt) (lu) (lv) (lw) (lx) (ly) (lz) (ma) (mb) (mc) (md) (me) (mf) (mg) (mh) (mi) (mj) (mk) (ml) (mn) (mo) (mp) (mq) (mr) (ms) (mt) (mu) (mv) (mw) (mx) (my) (mz) (na) (nb) (nc) (nd) (ne) (nf) (ng) (nh) (ni) (nj) (nk) (nl) (nm) (nn) (no) (np) (nq) (nr) (ns) (nt) (nu) (nv) (nw) (nx) (ny) (nz) (oa) (ob) (oc) (od) (oe) (of) (og) (oh) (oi) (oj) (ok) (ol) (om) (on) (oo) (op) (oq) (or) (os) (ot) (ou) (ov) (ow) (ox) (oy) (oz) (pa) (pb) (pc) (pd) (pe) (pf) (pg) (ph) (pi) (pj) (pk) (pl) (pm) (pn) (po) (pp) (pq) (pr) (ps) (pt) (pu) (pv) (pw) (px) (py) (pz) (qa) (qb) (qc) (qd) (qe) (qf) (qg) (qh) (qi) (qj) (qk) (ql) (qm) (qn) (qo) (qp) (qq) (qr) (qs) (qt) (qu) (qv) (qw) (qx) (qy) (qz) (ra) (rb) (rc) (rd) (re) (rf) (rg) (rh) (ri) (rj) (rk) (rl) (rm) (rn) (ro) (rp) (rq) (rr) (rs) (rt) (ru) (rv) (rw) (rx) (ry) (rz) (sa) (sb) (sc) (sd) (se) (sf) (sg) (sh) (si) (sj) (sk) (sl) (sm) (sn) (so) (sp) (sq) (sr) (ss) (st) (su) (sv) (sw) (sx) (sy) (sz) (ta) (tb) (tc) (td) (te) (tf) (tg) (th) (ti) (tj) (tk) (tl) (tm) (tn) (to) (tp) (tq) (tr) (ts) (tt) (tu) (tv) (tw) (tx) (ty) (tz) (ua) (ub) (uc) (ud) (ue) (uf) (ug) (uh) (ui) (uj) (uk) (ul) (um) (un) (uo) (up) (uq) (ur) (us) (ut) (uu) (uv) (uw) (ux) (uy) (uz) (va) (vb) (vc) (vd) (ve) (vf) (vg) (vh) (vi) (vj) (vk) (vl) (vm) (vn) (vo) (vp) (vq) (vr) (vs) (vt) (vu) (vv) (vw) (vx) (vy) (vz) (wa) (wb) (wc) (wd) (we) (wf) (wg) (wh) (wi) (wj) (wk) (wl) (wm) (wn) (wo) (wp) (wq) (wr) (ws) (wt) (wu) (wv) (ww) (wx) (wy) (wz) (xa) (xb) (xc) (xd) (xe) (xf) (xg) (xh) (xi) (xj) (xk) (xl) (xm) (xn) (xo) (xp) (xq) (xr) (xs) (xt) (xu) (xv) (xw) (xx) (xy) (xz) (ya) (yb) (yc) (yd) (ye) (yf) (yg) (yh) (yi) (yj) (yk) (yl) (ym) (yn) (yo) (yp) (yq) (yr) (ys) (yt) (yu) (yv) (yw) (yx) (yy) (yz) (za) (zb) (zc) (zd) (ze) (zf) (zg) (zh) (zi) (zj) (zk) (zl) (zm) (zn) (zo) (zp) (zq) (zr) (zs) (zt) (zu) (zv) (zw) (zx) (zy) (zz)					
22b. SIGNATURE <b>[Signature]</b>		22c. DATE SIGNED <b>6/9/81</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. E. C. Magarini</b>	
22e. ADDRESS <b>20 W. Edmonston Dr. Rockville</b>		22f. MEDICAL STAFF PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6-12-1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Marys cemetery Crucible</b>	
23d. LOCATION CITY OR TOWN <b>Greene</b> COUNTY <b>PA.</b> STATE <b>PA.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 11 1981</b>			
24. FUNERAL DIRECTOR <b>Warner E. Pumphrey, Inc. 8434 Ga. Ave., S.S. Md.</b>					

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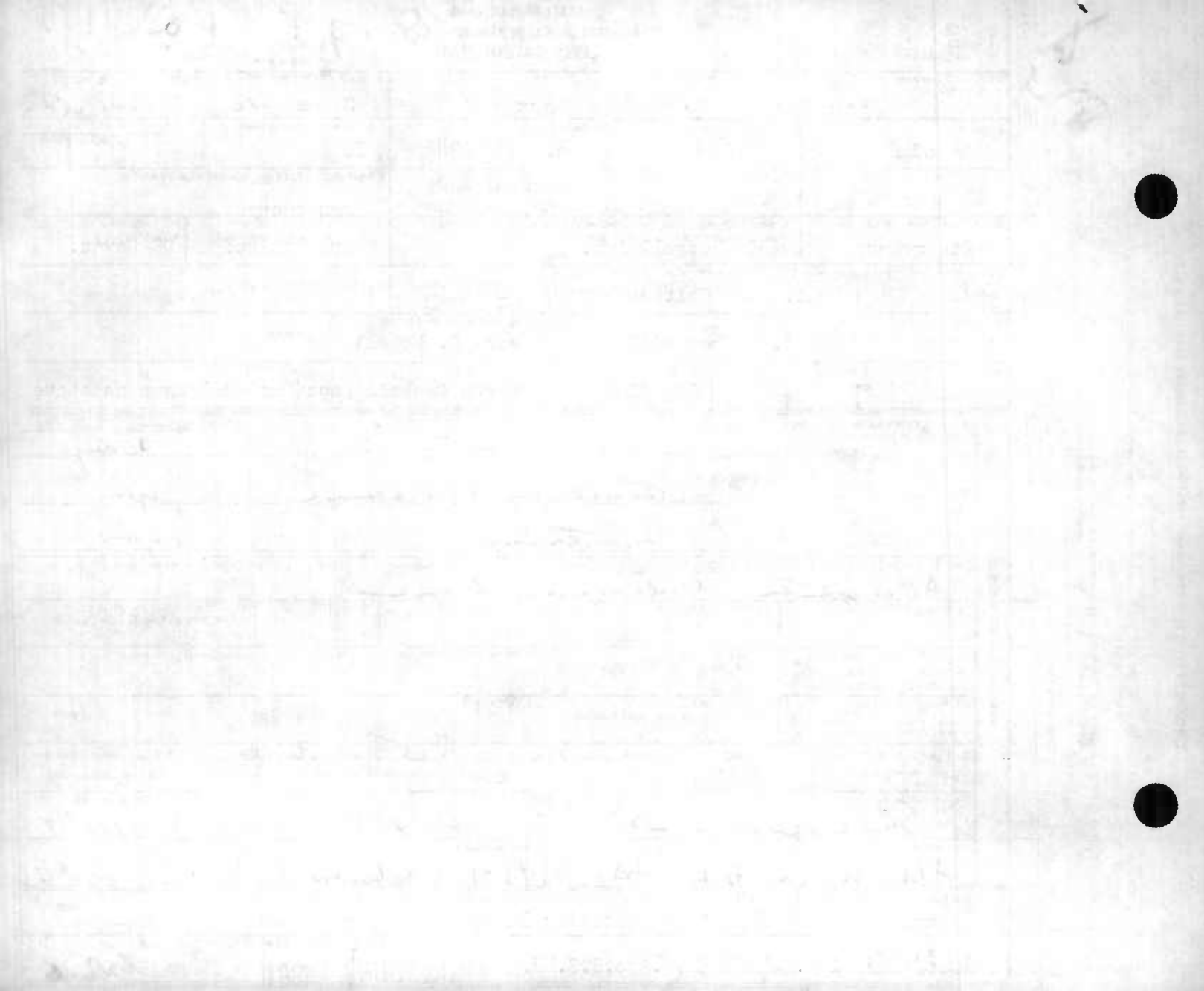
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 1 6 2 1 9	
1- FOR STATE REGISTRAR		REG. NO.									
1 DECEASED NAME (TYPE OR PRINT) <b>Pauline T. Best</b>				2a DATE OF DEATH MONTH DAY YEAR <b>June 10 1981</b>				2b HOUR <b>1:05 PM</b>			
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>Dec. 30 1904</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>76</b>		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN <b>YRS</b>			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Oklahoma</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.					
10 CITY OR TOWN OF DEATH <b>Gaithersburg</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>403 Russell Ave.</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk-Retired</b>		12b KIND OF BUSINESS OR INDUSTRY <b>US Gov't.</b>			
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Md.</b>				13b CITY OR TOWN <b>Mont.</b>		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d STREET ADDRESS <b>403 Russell Ave.</b>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>Alonzo A. Thornhill</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Nancy C. McCall</b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>None</b>		16b SOCIAL SECURITY NO. <b>579 01 8721B</b>		17 INFORMANT ADDRESS <b>George Cashell Best (Husband) Same as above</b>							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY (IMMEDIATE CAUSE (a)) <b>4140 Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hypertension</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Today</b> <b>yes</b> <b>yes</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Arteriosclerotic Cerebrovascular Disease</b>											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from <b>6/6</b> 19 <b>81</b> , to <b>6/10</b> 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>6/10</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <b>Alan Weinstein M.D.</b>				DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <b>6/10/81</b>			
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Alan Weinstein M.D.</b>				22e ADDRESS <b>1299 Lombard Ave. Silver Spring Md.</b>							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>6/13/81</b>		23c NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood PG Maryland</b>					
24 FUNERAL DIRECTOR NAME ADDRESS <b>Hines/Rinaldi F.H. 11800 N.H. Ave. S.S. Md.</b>				25a DATE REC'D. BY REGISTRAR <b>JUN 11 1981</b>		25b REGISTRAR'S SIGNATURE <b>[Signature]</b>					



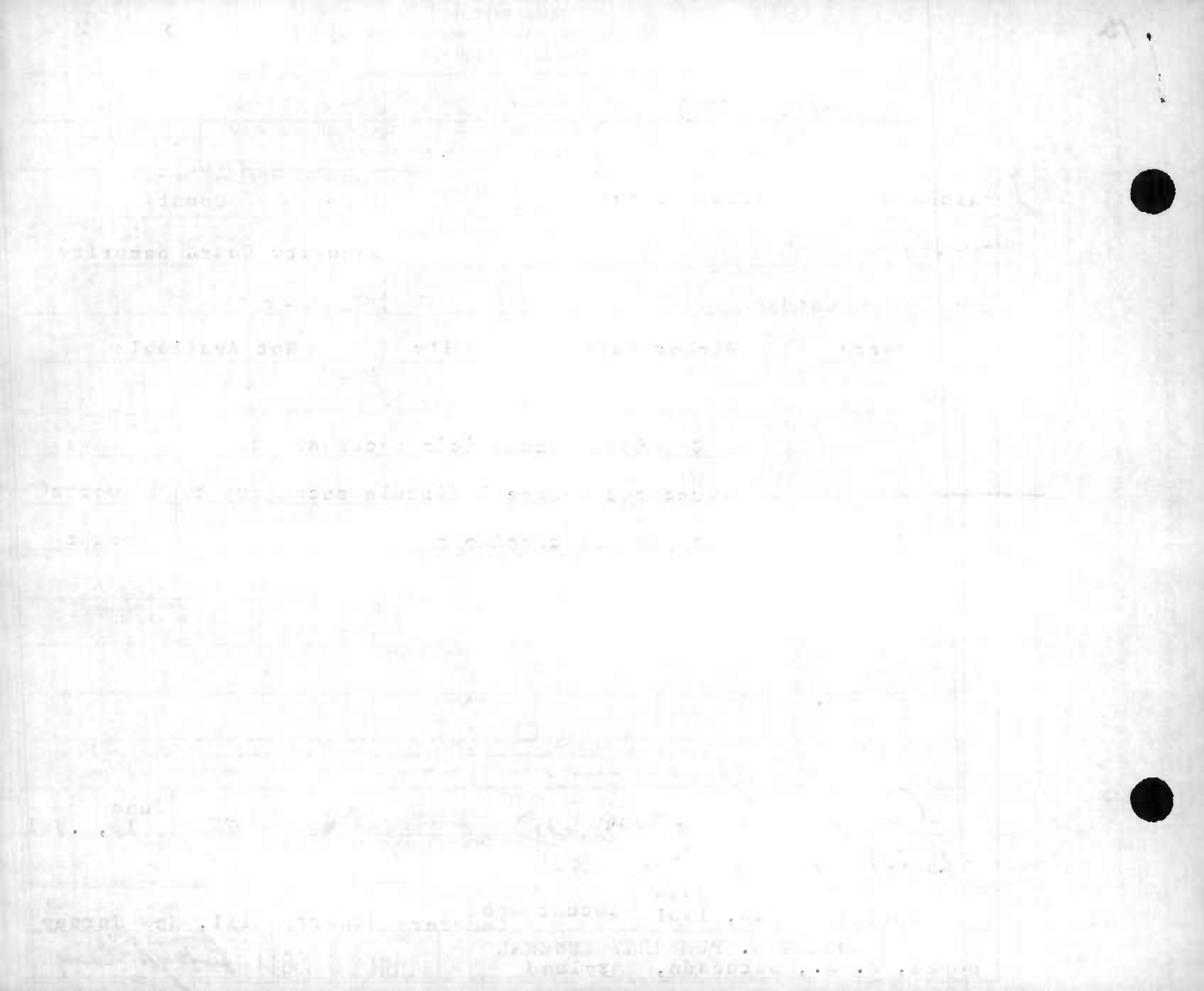
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR					8 1 1 6 2 2 0				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH MONTH DAY YEAR				
Herbert (NMN) Bickerstaff					June 17, 1981				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		2b. HOUR P M	
Male		Negro		January 30, 1904		77		4:00 M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Alabama		United States				Montgomery County		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda		Center, Bethesda, Md.				Security Guard		Security	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13b. INSIDE CITY LIMITS?				
13a. STATE CITY OR TOWN					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
New Jersey Camden Camden					13b. STREET ADDRESS				
2021 Watson St. 08105									
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
Jerry Bickerstaff					Emily Not Available				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					16b. SOCIAL SECURITY NO.				
No					062-05-6059				
17. INFORMANT (daughter)					ADDRESS 1208 Clements Bridge Rd., Barrington, NJ 08007				
Mrs. Brenda McIntyre									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) 1509 Chemical pneumonitis secondary to B days									
DUE TO, OR AS A CONSEQUENCE OF (b) Tracheoesophageal fistula secondary to C weeks									
DUE TO, OR AS A CONSEQUENCE OF (c) Esophageal carcinoma months									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
			P.M. 19						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 27, 1981, to June 17, 1981, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on June 17, 1981, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (If true, did <input checked="" type="checkbox"/> view the body after death.)									
22b. SIGNATURE					DEGREE			22c. DATE SIGNED	
[Signature]								June 18, 1981	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
Angelo Russo MD PhD					The Clinical Center, National Institutes of Health, Bethesda, Md. 20205				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial			June 23, 1981		Locust Wood Cemetery		Cherry Hill, New Jersey		
24. FUNERAL DIRECTOR NAME					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
ROBERT A. PUMPHREY FUNERAL Homes, P. A., Bethesda, Maryland					JUN 26 1981		[Signature]		





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, pages 1 and 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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DMMH - 16 50M / 181  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Hildegard</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>6/20/81</b>		2b. HOUR <b>6:40 AM</b>	
3. SEX <b>Female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Apr. 15, 1919</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Germany</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b>	
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hosp.</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Sil. Spring</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frank</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Wilhelmina Palstring</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>143-26-7257</b>		17. INFORMANT (husband) ADDRESS <b>Paul Bildin-(same as 13e)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Excessive Bladder Cancer</b> DUE TO, OR AS A CONSEQUENCE OF: (b) <b>Fatigue</b> DUE TO, OR AS A CONSEQUENCE OF: (c) <b>Excessive Bladder Cancer</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <b>Acute Cholecystitis, Spasmodic Adult Respiratory Distress Syndrome</b>					
19a. DATE OF OPERATION <b>6/6/81</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Acute Cholecystitis</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>6/5/81</b> , 19 <b>81</b> , to <b>6/20/81</b> , 19 <b>81</b> , that I (we) lost saw the deceased alive on <b>6/20/81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>H. L. M. ARTER</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>6-20-1981</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>H. L. M. ARTER</b>		22e. ADDRESS <b>331 Kneeling Blvd East</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6-23-1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Fladimir Cemetery Jackson</b>	
24. FUNERAL HOME NAME <b>Wanner E. Pumphrey, Inc.</b>		24b. ADDRESS <b>8434 Ga. Ave., S.S. Md</b>		25a. DATE REC'D. BY REGISTRAR <b>"JUN 23 1981"</b>	
25b. REGISTRAR'S SIGNATURE <b>John E. E. E.</b>		25c. REGISTRAR'S NAME <b>John E. E. E.</b>			

MEDICAL CERTIFICATION

4600

BP



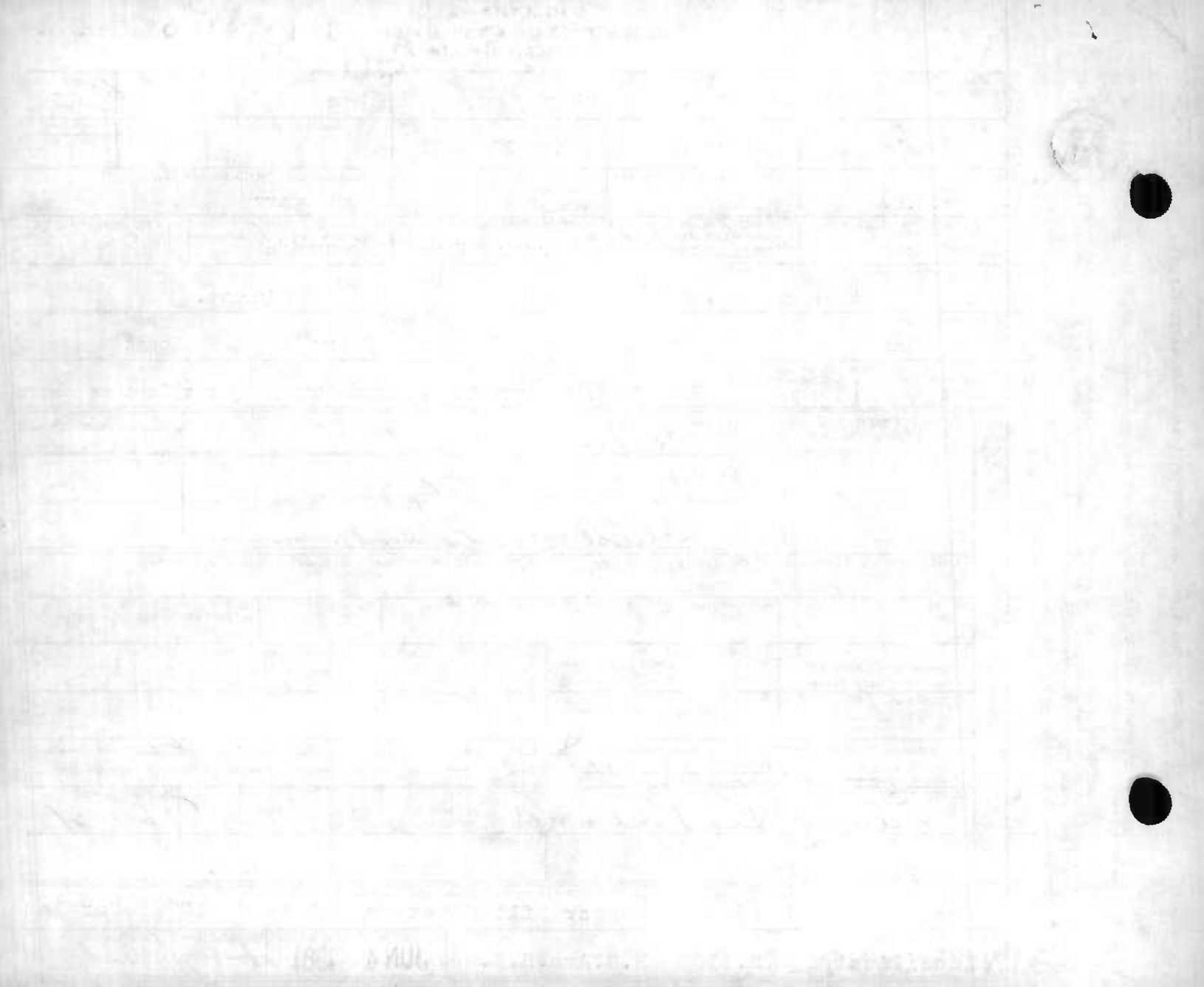
*[Faint, illegible handwritten text at the bottom of the page]*

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 1 6 2 2 2		
1. FOR STATE REGISTRAR			REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) Margaret E. Birmingham			2a. DATE OF DEATH June 1, 1981			2b. HOUR A 8:25 AM						
3. SEX Female		4. RACE White		5. DATE OF BIRTH Nov. 12 1884		6. AGE (IN YEARS LAST BIRTHDAY) 96		7. IF UNDER 1 YEAR MONTHS DAYS		7b. HOUR A HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD						
10. CITY OR TOWN OF DEATH Kensington		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kensington Gardens Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE Md.			13b. COUNTY Mont		13c. CITY OR TOWN S.S.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2110 Dennis Ave.			
14. FATHER'S NAME Charles			15. MOTHER'S MAIDEN NAME Ellen Mary Mount									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) None			16b. SOCIAL SECURITY NO 577 09 0477D		17. INFORMANT ADDRESS Aurelia L. Birmingham (Daughter) Same as above							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ventricular tachycardia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Heart disease</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>July 2, 19 65</u> , to <u>June 1, 19 81</u> , that (I) (we) last saw the deceased alive on <u>May 15, 19 81</u> , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.												
22b. SIGNATURE <u>Edward Richards</u>			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 6-1-81						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Edward Richards			22e. ADDRESS 10301 Georgia Ave. S.S.Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6/4/81		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG Maryland				
24. FUNERAL DIRECTOR NAME Hines/Rinaldi			F.H. 11800			ADDRESS N.H. Ave. S.S.Md.			25a. DATE REC'D. BY REGISTRAR JUN 4 1981		25b. REGISTRAR'S SIGNATURE <u>Hines/Rinaldi</u>	



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 6 2 2 3

FOR - STATE REGISTRAR			REG. NO.		
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Harold A LLEN Bitting</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6-16-81</b>		
3. SEX <b>MALE</b>			2b. HOUR <b>3:40</b> M		
4. RACE <b>CAUCASIAN</b>			6. AGE (IN YEARS LAST BIRTHDAY) MONTH DAY YEAR <b>70</b>		
5. DATE OF BIRTH MONTH DAY YEAR <b>3-10-11</b>			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PENNSYLVANIA</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.		
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>BUS DRIVER D.C.</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>TRANSIT CO.</b>		
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>MONTGOMERY</b>		
13c. CITY OR TOWN <b>KENSINGTON</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS <b>3135 UNIVERSITY BLVD., WEST</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>GEORGE BITTING</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>KATHRYN CREGLow</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>178-05-0961</b>		
17. INFORMANT <b>BERNICE M. BITTING</b>			ADDRESS <b>SAME AS 13 WIFE</b>		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic Bronch Syndrome</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Brumoni H. Left and right</b> 4866 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Unimpaired</b>					
19a. DATE OF OPERATION <b>NA</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NA</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Kamalini V Deshpande</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>6 16 81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KAMALINI V DESHPANDE</b>		22e. ADDRESS <b>50 W E D H G N S 2000 Pk, Rockville, MD 20850</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>6/19/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>BRENTWOOD PRI GEO MD.</b>					
24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b>		ADDRESS <b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 22 1981</b>	
25b. REGISTRAR'S SIGNATURE <b>Patricia K. Brown</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

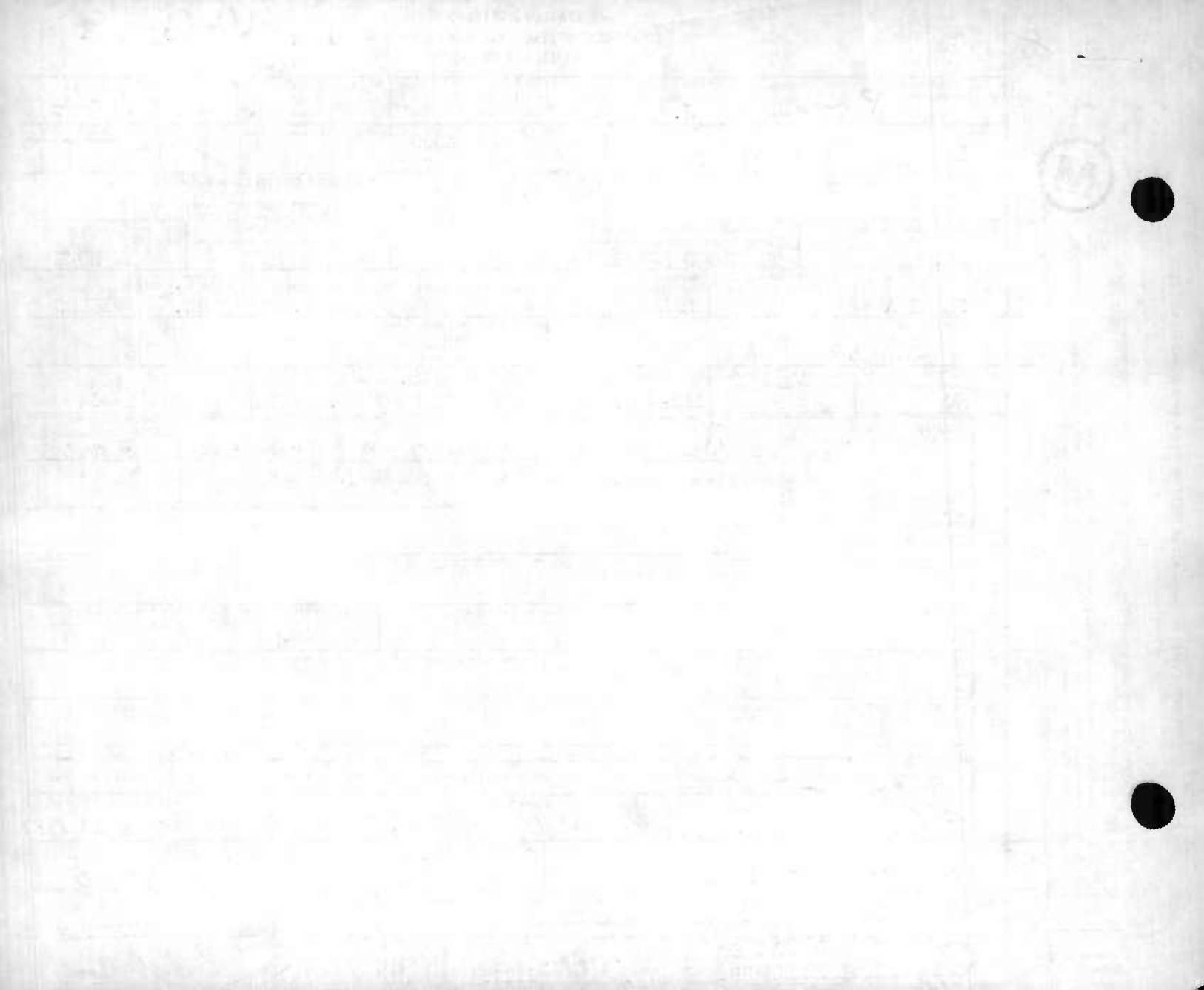
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Rose J. Block</b>			2a. DATE OF DEATH MONTH <b>6</b> DAY <b>23</b> YEAR <b>81</b>		2b. HOUR <b>8</b> P M	
3 SEX <b>F</b> FEMALE	4 RACE <b>W</b> WHITE	5 DATE OF BIRTH MONTH <b>12</b> DAY <b>20</b> YEAR <b>1899</b>	6 AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS.		7. IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY COUNTY MD</b>			
10 CITY OR TOWN OF DEATH <b>BETHESDA</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FERNWOOD NURSING HOME</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	
13a. STATE <b>FLORIDA</b>		13b. COUNTY <b>HALLANDALE</b>	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS <b>APT. 504 3180 S. OCEAN DR. #33009</b>		
14 FATHER'S NAME FIRST <b>SAMUEL</b> MIDDLE <b>JURICK</b> LAST <b>JURICK</b>			15 MOTHER'S MAIDEN NAME FIRST <b>KATE</b> MIDDLE <b>MARCUS</b> LAST <b>MARCUS</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>213-48-7034</b>		17 INFORMANT <b>MRS. ELEANOR STIRKIS</b> <b>6207 ROCKHURST RD., BETHESDA, MD 20034</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA, PRIMARY</b> <b>1991</b> DUE TO, OR AS A CONSEQUENCE OF <b>SITE UNDETERMINED</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 MOS</b>						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22. I certify that (I) (the hospital) attended the deceased from <b>DEC 19 80</b> to <b>JUNE 23 19 81</b> , that (I) (we) last saw the deceased alive on <b>JUNE 23 19 81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>Edward A. Beeman</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>JUNE 23, 1981</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>EDWARD A. BEEMAN</b>		22e. ADDRESS <b>8830 CAMERON ST. SILVER SPRING MD 20910</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>6/26/81</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CHIZUK AMUNO</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>	
24 FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b> <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 2 1981</b>		25b. REGISTRAR'S SIGNATURE <b>L. J. Brady</b>

BP



NO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 6 2 2 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Therese W. Bonnivier</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>June 29, 1981</b>			2b. HOUR <b>3 55 AM</b>				
3 SEX <b>Female</b>		4 RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 5 1901</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Illinois</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County, MD.</b>				
10 CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Collingswood Nursing Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Rockville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>10233 Seven Locks Road</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Henry H. Walther</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emma Sternberg</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>no</b>				16b. SOCIAL SECURITY NO. <b>331-26-8587</b>		17 INFORMANT ADDRESS <b>Elizabeth B. Whicher, Same as 13</b>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic Failure.</b> 5715 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cirrhosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>10</u> 19 <u>50</u> to <u>6</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>6-23</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>John E. Kelly</b>				DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>6-29-81</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN E. Kelly</b>				22e. ADDRESS <b>9715 Medical Center Drive, Rockville MD 20850</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>July 2, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hope Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Chicago Illinois</b>		
24 FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey</b>					ADDRESS <b>300 W. Montgomery Ave., Rockville, Maryland</b>			25a. DATE REC'D. BY REGISTRAR <b>JUL 8 1981</b>		

*[Faint, mostly illegible text covering the majority of the page, possibly bleed-through from the reverse side.]*

100 N. Jackson Ave. Chicago, Ill. 60604  
JUL 8 1961  
J. Edgar Hoover  
Chicago, Ill.  
JUL 8 1961  
J. Edgar Hoover  
Chicago, Ill.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2b. DATE OF DEATH			2c. HOUR		
MABEL H. BOWLES			6 24 81			2:30 PM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
FEMALE	CAUCASIAN	MAY 26, 1897	84 YRS.			MONTHS DAYS HOURS MIN.		
8a. BIRTHPLACE (COUNTRY)	8b. CITIZEN OF WHAT COUNTRY?	8c. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
WEST VIRGINIA	U.S.A.		MONTGOMERY MD					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
SILVER SPRING	2010 HANOVER STREET			HOUSEWIFE				
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
MARYLAND			MONTGOMERY			SILVER SPRING		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. STREET ADDRESS		
JOHN H. HUNTER			BETTY S. ECHARD			2010 HANOVER STREET		
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			17b. SOCIAL SECURITY NO.			17. INFORMANT		
NO			578-54-2734			DAUGHTER BETTY B. BRITTON		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (a) <u>myocardial infarction</u>			1 HR					
DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic heart disease</u>			20 YRS					
DUE TO, OR AS A CONSEQUENCE OF (c) <u>arteriosclerosis</u>			30 YRS					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (b) <u>congestive heart failure</u>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		
						YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>1960</u> , 19 <u>81</u> , to <u>1981</u> , that (I) (we) last saw the deceased alive on <u>6/24</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE <u>H. W. Stout</u> MD			22c. DATE SIGNED 6/25/81		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			22f. SIGNATURE		
H. W. STOUT MD			10829 GEORGIA AVE			SILVER SPRING MD		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY		
BURIAL			6/26/81			ARLINGTON NATIONAL		
23d. LOCATION CITY OR TOWN COUNTY STATE			23e. DATE REC'D. BY REGISTRAR			23f. REGISTRAR'S SIGNATURE		
ARLINGTON VIRGINIA			JUN 30 1981			<u>[Signature]</u>		
24. FUNERAL DIRECTOR NAME ADDRESS			25. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901			JUN 30 1981			<u>[Signature]</u>		

MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR

2. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

3. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

NOTED 2/20/01



JUN 12 1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

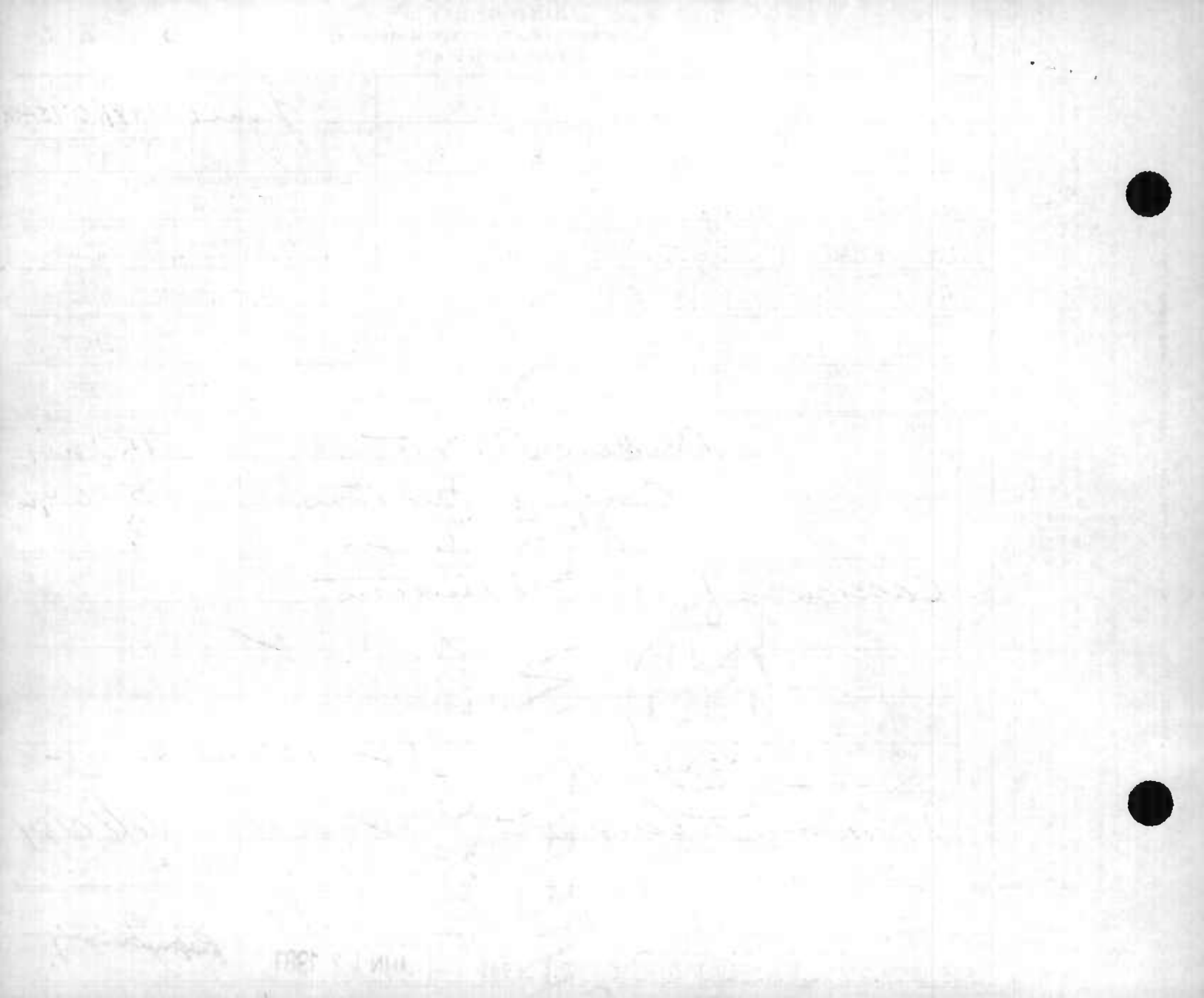
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR										8 1 1 6 2 2 7	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LEO W. BOYER					2a. DATE OF DEATH MONTH DAY YEAR June 10, 1981 10:15 AM			2b. HOUR			
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR MARCH 23 1903		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 509 EAST SCHUYLER ROAD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PRINTER NATL.		12b. KIND OF BUSINESS OR INDUSTRY EDUCATION ASSN.			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 509 EAST SCHUYLER ROAD			
14. FATHER'S NAME FIRST MIDDLE LAST JOHN L. BOYER					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BERTHA M. WEAVER						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 577-30-8889		17. INFORMANT ESTHER C. BOYER		ADDRESS SAME AS 13		WIFE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 4130 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Angine pectoris</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 min 5-6 yrs ?											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>Carcinoma of Colon &amp; Metastases</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>29 May 1981</u> to <u>10 June 1981</u> , that (I) (we) last saw the deceased alive on <u>29 May 1981</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE (Type or Print) William D. Aud					DEGREE ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 6/6/81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM D. AUD					22e. ADDRESS 9006 COLESVILLE ROAD, SILVER SPRING, MD.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6/12/81		23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN		23d. LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD PRI GEO MD.					
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS					25a. DATE REC'D. BY REGISTRAR JUN 12 1981		25b. REGISTERED				
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901											

MEDICAL CERTIFICATION

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2200





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

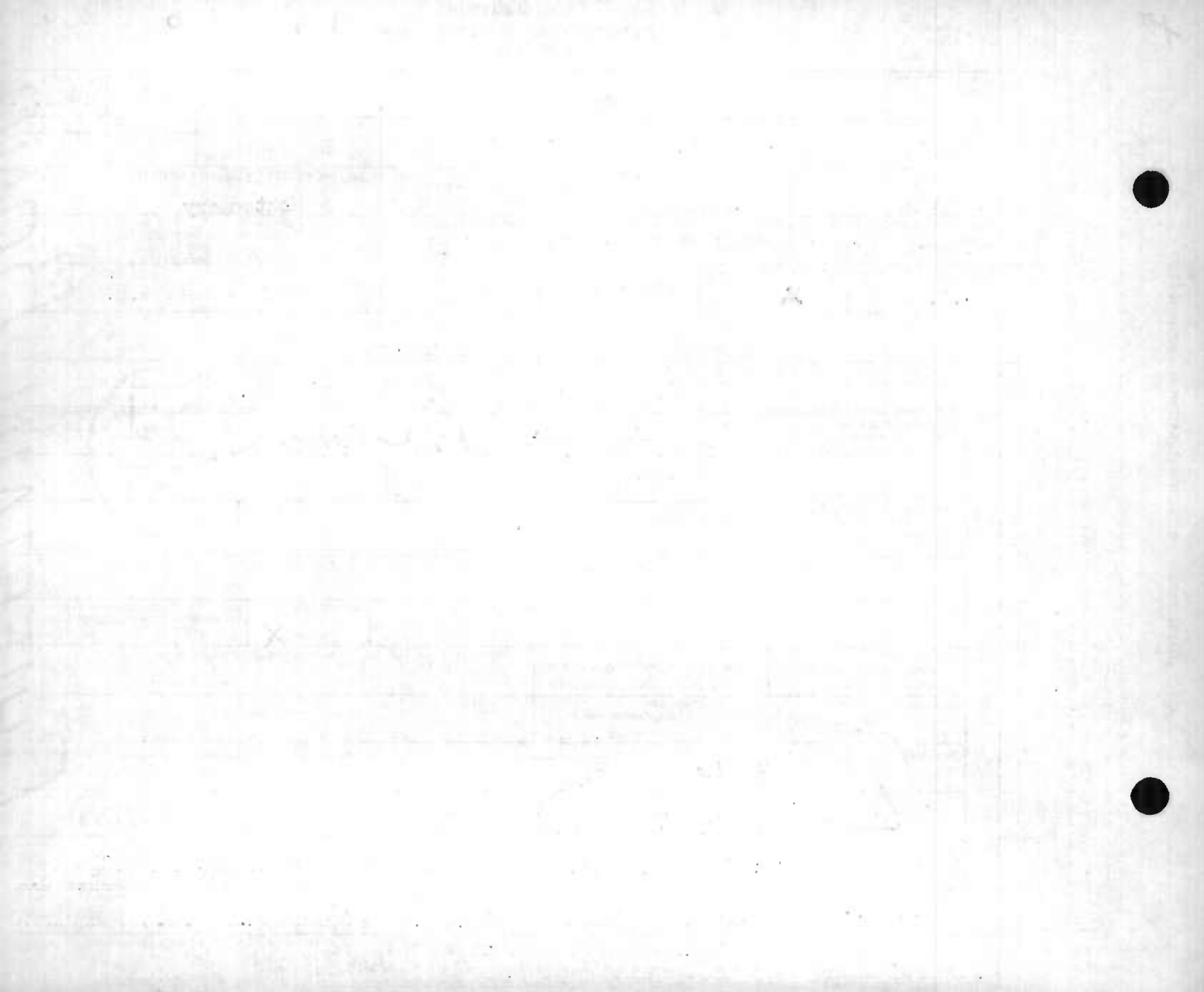
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 1 1 6 2 2 8					
1. DECEASED NAME (TYPE OR PRINT) <b>Winifred</b>				MIDDLE <b>Brennan</b>				2a. DATE OF DEATH MONTH <b>6</b> DAY <b>17</b> YEAR <b>81</b>				2b. HOUR <b>1:40a.m.</b>	
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MO <b>10</b> DAY <b>14</b> YEAR <b>16</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b>		IF UNDER 1 YEAR MONTHS <b>YRS.</b>		IF UNDER 24 HRS HOURS <b>MIN.</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>England</b>		7b. CITIZEN OF WHAT COUNTRY? <b>England</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.							
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Processing, Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>C &amp; P</b>					
13a. STATE <b>D.C.</b>		13b. COUNTY <b>NA</b>		13c. CITY OR TOWN <b>Washington</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4502 Texas Avenue, S.E.</b>					
14. FATHER'S NAME FIRST <b>James</b> MIDDLE <b>Field</b> LAST <b>Field</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Not Known</b> MIDDLE <b>Not Known</b> LAST <b>Not Known</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>578-52-4873</b>		17. INFORMANT <b>James M. Brennan, Son;</b>				ADDRESS <b>3930 26th Ave., Hillcrest Hgts., Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial infarction</b> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <b>April 4</b> , 19 <b>81</b> , to <b>June 17</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>6/16</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>Lewis Hilliard Dennis</b>				DEGREE <b>M.D., P.A.</b>				22c. DATE SIGNED <b>6/17/81</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Lewis Hilliard Dennis, M.D., P.A.</b>				22e. ADDRESS <b>831 University Blvd., East, Ste 35 Silver Spring, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6-19-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>		23d. LOCATION CITY OR TOWN <b>Suitland, P.G., Maryland</b> COUNTY <b>Prince George's</b> STATE <b>Md.</b>							
24. FUNERAL DIRECTOR NAME <b>Robt E Wilhelm</b>		ADDRESS <b>4308 Suitland Rd., Suitland, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 22 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Lester</b>							

BP

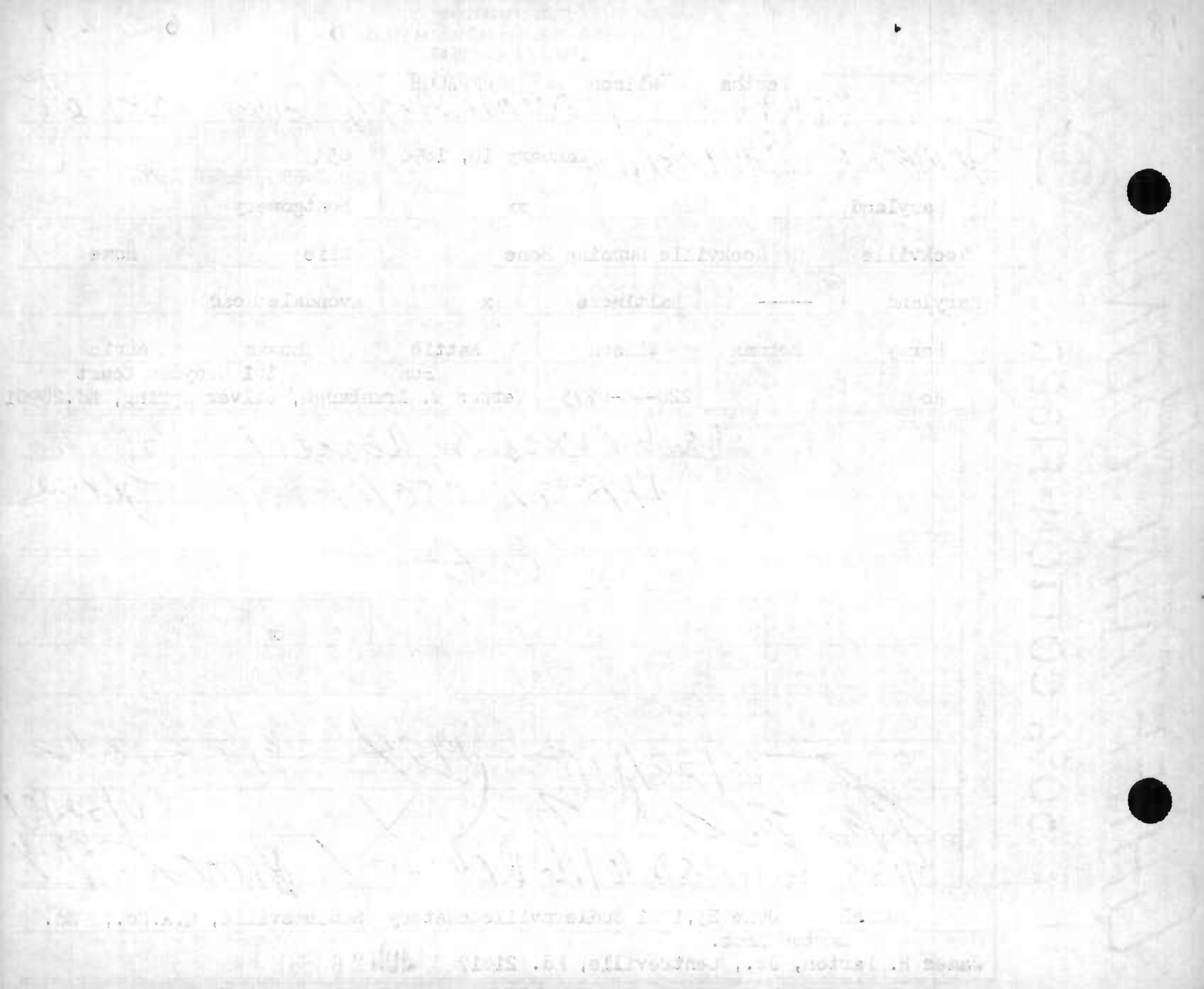


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1- FOR STATE REGISTRAR									
CERTIFICATE OF DEATH									
REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) <i>Bertha Wilson BRUMBAUGH</i>				2a. DATE OF DEATH MONTH DAY YEAR 22.8.1981					
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR January 10, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		7b. HOUR <i>10:55</i>	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7c. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.			
10. CITY OR TOWN OF DEATH <i>Rockville</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Rockville Nursing Home</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Wife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <i>Maryland</i>		13b. COUNTY <i>---</i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>Avondale Road</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Harry Norman Wilson</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mattie Thomas Merrick</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>				16b. SOCIAL SECURITY NO. <i>220-48-0775</i>		17 INFORMANT <i>Son</i> <i>1015 Croydon Court</i> <i>Vernon W. Brumbaugh, Silver Spring, Md. 20901</i>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. <i>Cerebrovascular Accident</i> <i>4360</i> IMMEDIATE CAUSE (a) <i>4360</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>ARTERIOSCLEROSIS</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Stroke</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i> <i>years</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Stroke</i>									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT HOME				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (i) (the hospital) attended the deceased from <i>6/20/81</i> to <i>6/22/81</i> and that in my (best) opinion death occurred on the date and hour and from the causes stated above. (i) (we) (did not) view the body after death.									
22b. SIGNATURE <i>Thos G. Ward</i>				22c. DATE SIGNED <i>6/22/81</i>				22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Thos G. Ward</i>				22f. ADDRESS <i>6116 Rockwood, Bethesda, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>June 25, 1981</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Sudlersville Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Sudlersville, Q.A.Co., Md.</i>			
24 FUNERAL DIRECTOR <i>Barton Bros.</i>				25a. DATE REC'D. BY REGISTRAR <i>JUN 26 1981</i>		25b. REGISTRAR'S SIGNATURE <i>Jeffrey McBrady</i>			
26. NAME ADDRESS <i>James H. Barton, Jr., Centreville, Md. 21617</i>									



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE Thelma LAST Brunelle			2a. DATE OF DEATH MONTH DAY YEAR 6-13-81			2b. HOUR 7:50 PM			
3 SEX F		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 12, 1907		6 AGE (IN YEARS LAST BIRTHDAY) 74 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery			
10 CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY Real estate	
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md 13b. COUNTY PG 13c. CITY OR TOWN Hyattsville			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5801 44th Avenue				
14 FATHER'S NAME FIRST MIDDLE LAST N. Edward Donaldson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Stewart Baldwin						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 214 16 7147A		17 INFORMANT ADDRESS Marian Donaldson 5806 42nd Ave, Hyattsville					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1729 IMMEDIATE CAUSE (a) METASTATIC MALIGNANT MELANOMA DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 mos
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from APRIL 21, 1981, to JUNE 13, 1981, that (we) lost the deceased alive on JUNE 12, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.									
22b. SIGNATURE James A. Brown, MD						DEGREE MD		22c. DATE SIGNED 6/14/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James A. Brown, MD						22e. ADDRESS 6321 BELCREST RD HYATTSVILLE, MD 20782			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE June 17, 1981		23c. NAME OF CEMETERY OR CREMATORY St Stephens Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Bradshaw, Md		
24 FUNERAL DIRECTOR NAME Donaldson Funeral Home, Laurel, Md						25a. DATE REC'D. BY REGISTRAR JUN 19 1981		25b. REGISTRAR'S SIGNATURE [Signature]	





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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			REG. NO.				8 1 1 6 2 3 1		
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Henry W Buckler</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>6-23-81</b>		2b. HOUR <b>6:52 P.M.</b>	
3 SEX <b>male</b>		4 RACE <b>white</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>12 26 03</b>		6 AGE (IN YEARS LAST BIRTHDAY) YRS <b>77</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>77</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Navy Cross Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>POWER DISPATCHER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>PEPCO</b>	
13a. STATE <b>DC</b>						13b. CITY OR TOWN <b>Wash.</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>JOHN W. BUCKLER</b>						15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANNA GATTON</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>577-09-3951</b>		17 INFORMANT <b>DAUGHTER MARGARET CAIN</b>		ADDRESS <b>12901 FOREST VIEW DR BELTSVILLE, MD.</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident - left</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic cerebrovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>4360</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Arteriosclerotic cardiovascular disease; Diabetes Mellitus</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED, WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>June 19, 1977</b> to <b>June 23, 1981</b> , that (I) (we) lost saw the deceased alive on <b>June 23, 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Marvin Schneider, M.D.</b>				DEGREE <b>M.D.</b>				22c. DATE SIGNED <b>6/23/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARVIN SCHNEIDER, M.D.</b>				22e. ADDRESS <b>12001 Fernside Ave., Wheaton, Md 20906</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>6/27/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>SILVER SPRING MONT MD</b>			
24 FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 30 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Francis J. Collins</b>			
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901									

1981 JUL 30

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>DOUGLAS HARMON BURCH</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>June 27, 1981</b>			2b. HOUR pm <b>4:26 M</b>			
3. SEX <b>MALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JUNE 24, 1929</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>52 YRS</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WASHINGTON, DC</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD.</b>			
10. CITY OR TOWN OF DEATH <b>Olney</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>FINANCIAL ANALYST</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>SMALL BUSIN ADM.</b>	
13a. STATE <b>MARYLAND</b>		13b. CITY OR TOWN <b>MONTGOMERY</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>14125 CHADWICK LANE</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>FRANK H. BURCH</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>RUBY ROBINSON</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO (IF NOT KNOWN, GIVE DATES) <b>KOREAN</b>		17. INFORMANT <b>SHIRLEY T. BURCH</b>		ADDRESS <b>SAME AS 13</b>		WIFE	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Myeloma</b> <b>2030</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>18 mo</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Systemic amyloidosis with pulmonary, cardiac, hepatosplenic involvement. Poss. CVA</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan</b> , 19 <b>80</b> , to <b>27 June</b> , 19 <b>81</b> , that (I) (not) last saw the deceased alive on <b>22 June</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Donald E. Dillon MD</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>27 June 81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>18111 Pr Philip Dr Olney, Md 20832</b>				22e. ADDRESS <b>Donald E. Dillon, M.D.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>7/1/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MARYLAND NATIONAL VET.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>CHELTENHAM PRI GEO MD.</b>			
24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b>				25a. DATE REC'D. BY REGISTRAR <b>20901 JUN 30 1981</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

MEDICAL CERTIFICATION

Cleared by *med Examiner or Registrar*

1981 08 01

RECEIVED



1981 08 01

1981 08 01

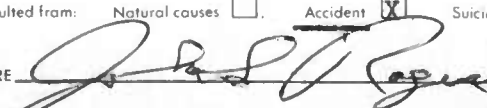

1981 08 01

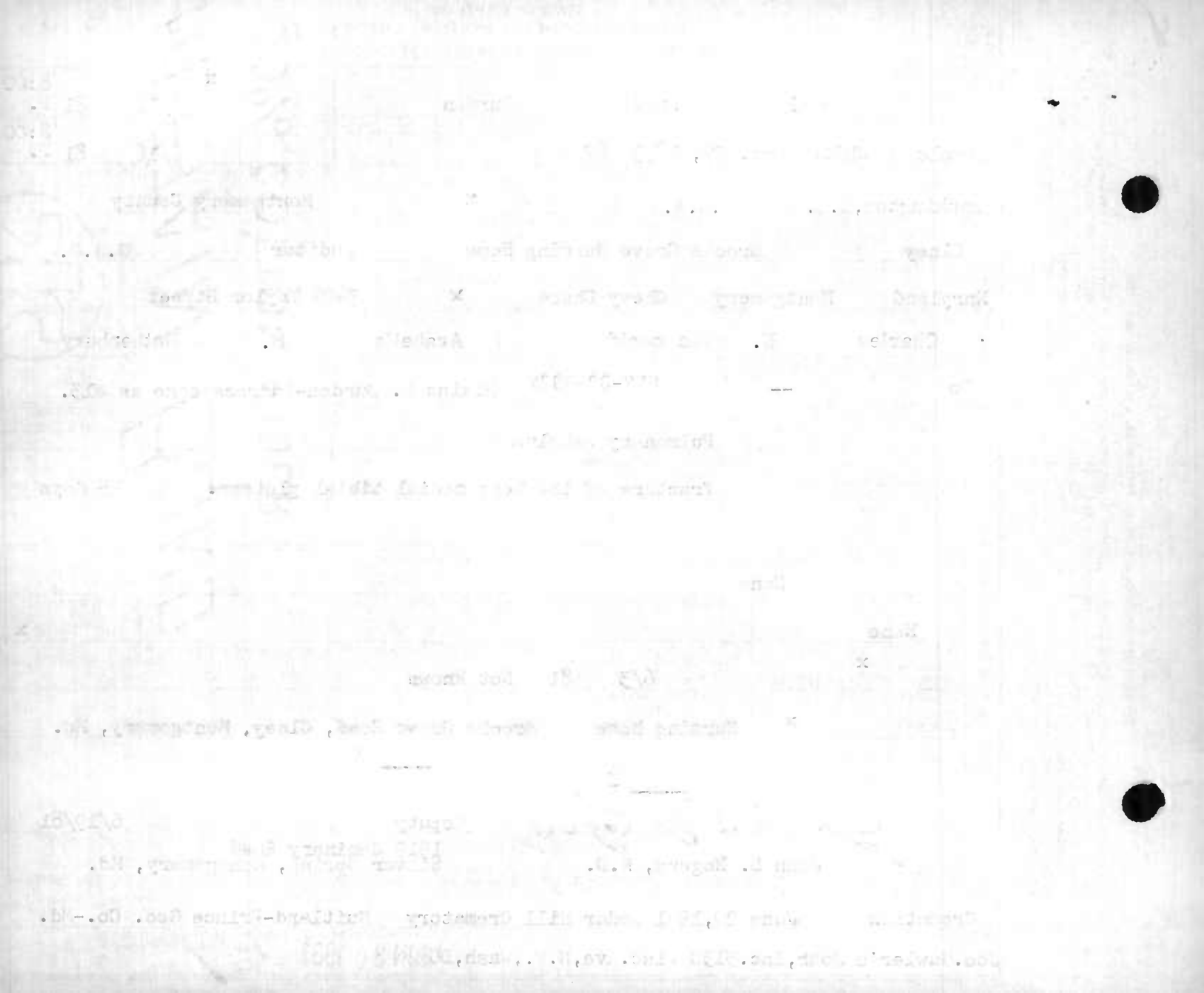
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH THE 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 1 6 2 3 3	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) <b>Belle Austin Burden</b>								2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> <b>6/18 19 81</b>	
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 27, 1893</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>87 YRS</b>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD <b>6/18 19 81</b>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b>		20. HOUR P.M. <b>8:00 P. M.</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Auditor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>G.A.O.</b>			
10. CITY OR TOWN OF DEATH <b>Olney</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Brooke Grove Nursing Home</b>				13a. STREET ADDRESS <b>3407 Taylor Street</b>					
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Chevy Chase</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles H. McDonald</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Arabella N. Rothenbury</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>				16b. SOCIAL SECURITY NO. <b>577-30-5387</b>		17. INFORMANT ADDRESS <b>Blaine H. Burden-Address same as #13.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary embolus</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>fracture of the left medial tibial plateau.</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 days</b>											
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>None</b>											
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>6/3 19 81</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>Not known</b>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Nursing home</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Brooke Grove Road, Olney, Montgomery, Md.</b>							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 				TITLE (SPECIFY) <b>Deputy</b>		MEDICAL EXAMINER		DATE SIGNED <b>6/19/81</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers, M.D.</b>				ADDRESS <b>1919 Seminary Road Silver Spring, Montgomery, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>June 20, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland-Prince Geo. Co.-Md.</b>					
24. FUNERAL DIRECTOR NAME <b>Jos. Gawler's Sons, Inc.</b>				ADDRESS <b>5130 Wisc. Ave, N.W., Wash, D.C.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 30 1981</b>		25b. REGISTRAR'S SIGNATURE 			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1 - FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) JOHANNES M. BURGERS					2a. DATE OF DEATH MONTH DAY YEAR June 7, 1981			2b. HOUR 7:16 P.M.	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JAN. 13, 1895		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) HOLLAND		7b. CITIZEN OF WHAT COUNTRY? HOLLAND		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.			
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SLIGO GARDENS NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) COLLEGE PROFESSOR		12b. KIND OF BUSINESS OR INDUSTRY EDUCATION	
13a. STATE MARYLAND		13b. COUNTY P.G. CO.		13c. CITY OR TOWN HYATTSVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3450 TOLEDO TERRACE # 517	
14. FATHER'S NAME FIRST MIDDLE LAST JOHANNES M. BURGERS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JOHANNA - ROMYN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 579-44-9601		17. INFORMANT ADDRESS ANNA BURGERS (WIFE) SAME AS # 13.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 3320 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Parkinson's Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>4-15</u> , 19 <u>81</u> , to <u>6/8</u> , 19 <u>81</u> , that (I) (we) last saw the deceased <u>above</u> , (I) (we) <u>did not</u> view the body after death, 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated									
22b. SIGNATURE <u>[Signature]</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED JUNE 7, 1981	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. ABRAHAM DABELLA, M.D.				22e. ADDRESS 4400 QUEENSBURY RD. RIVERDALE, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE JUNE / 81		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE SUITLAND, P.G. CO., MARYLAND			
24. FUNERAL DIRECTOR NAME CHAMBERS FUNERAL HOME RIVERDALE, MARYLAND				25a. DATE REC'D. BY REGISTRAR JUN 15 1981		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			





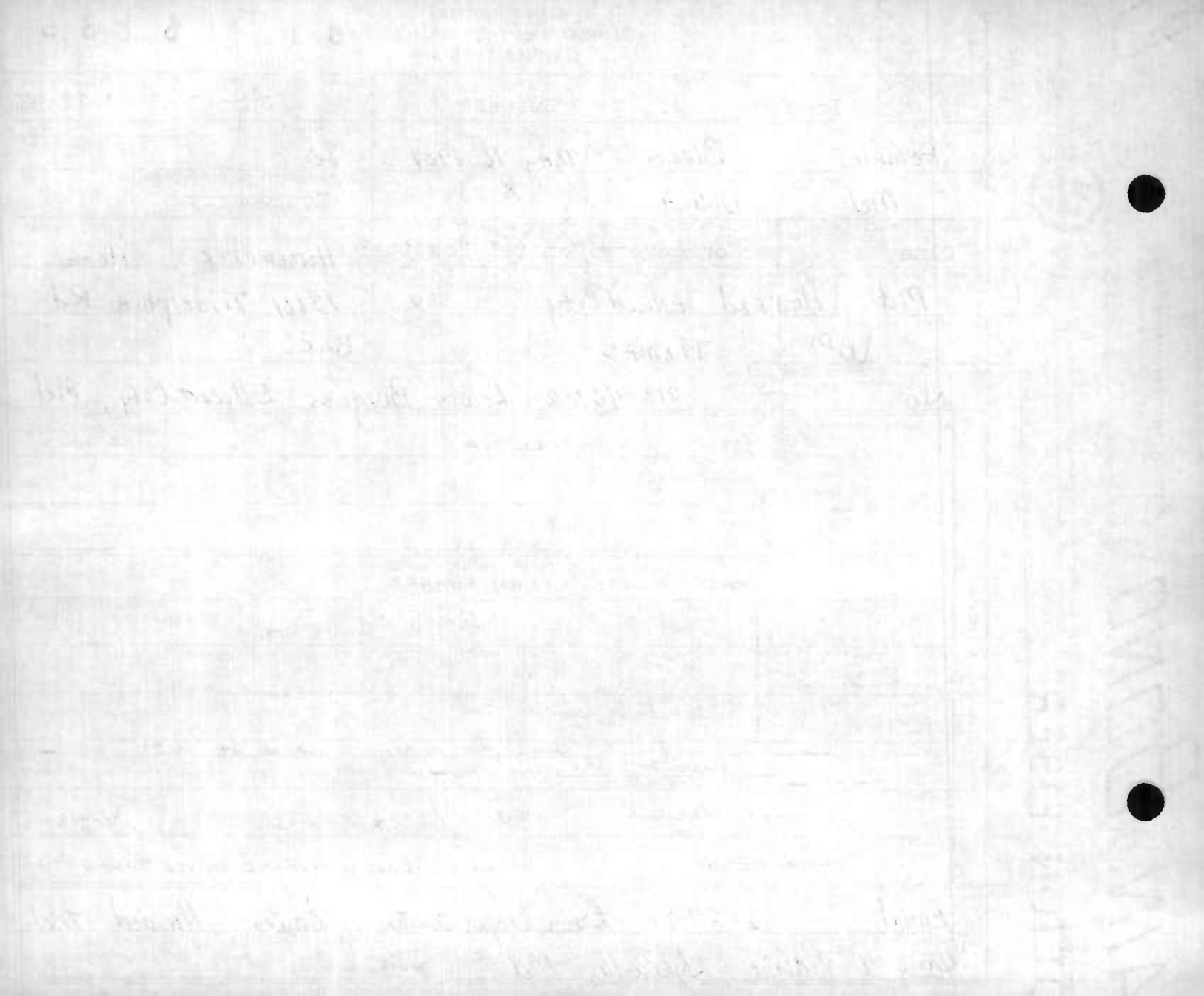
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 1 1 6 2 3 5	
1- FOR STATE REGISTRAR				CERTIFICATE OF DEATH						REG. NO.	
1 DECEASED NAME (TYPE OR PRINT)				FIRST MIDDLE LAST				2a DATE OF DEATH MONTH DAY YEAR		2b HOUR	
Blanche				V.				Burgess		June 24, 1981 12:02 PM	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7 UNDER 1 YEAR MONTHS DAYS		7 UNDER 24 HRS HOURS MIN.	
Female		Black		May 16, 1901		80					
8 BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Md.		U.S.A.				Montgomery MD.					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Olney		Montgomery General Hospital						Homemaker		Home	
13a USUAL RESIDENCE (IF IN HOSPITAL, HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b CITY OR TOWN		13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d STREET ADDRESS					
Md.		Howard		Ellicott City		13101 Tridelphia Rd.					
14 FATHER'S NAME FIRST MIDDLE LAST				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Wm Thomas				Unk.							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT ADDRESS					
No				-		218340902 Lewis Burgess Ellicott City, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
0389 IMMEDIATE CAUSE (a) SEPTICEMIA										3 Days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c) DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
HEART FAILURE, KIDNEY FAILURE											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (the hospital) attended the deceased from June 9, 1981, to June 24, 1981, that (I) (we) last saw the deceased alive on June 24, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE Barry Hecht						DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 6/24/81			
22d PHYSICIAN'S NAME (TYPE OR PRINT) BARRY HECHT						22e ADDRESS 10620 GEORGIA AVENUE SILVER SPRING, MD					
23a BURIAL, CREMATION, REMOVAL (SPECFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE					
Burial		6-27-81		Brown Chapel Cemetery		Dayton Howard Md.					
24 FUNERAL DIRECTOR Harry W. Haight						ADDRESS Sykesville, Md.		25a DATE REC'D. BY REGISTRAR JUN 29 1981		25b REGISTRAR'S SIGNATURE [Signature]	

BP



# CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>Lester T. Burn</b>			2a. DATE OF DEATH Month <b>June</b> Day <b>27</b> Year <b>1981</b>			2b. HOUR <b>10:05</b>				
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>November 21, 1905</b>		6. AGE (In years last birthday) <b>75</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.		
7a. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery County, Md.</b>			
10. CITY OR TOWN OF DEATH <b>Bethesda</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Suburban Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Architect</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Potomac</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>11736 Gainsborough Road</b>	
14. FATHER'S NAME First <b>James</b> Middle <b>D.</b> Last <b>Burn</b>			15. MOTHER'S MAIDEN NAME First <b>Lotta</b> Middle <b>Lee</b> Last <b>Dant</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b>			16b. SOCIAL SECURITY NO. <b>579-34-6472</b>		17. INFORMANT Address <b>Susie K. Burn, Same as 13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CORONARY INSUFFICIENCY</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ARTERIO-SCLEROSIS</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>ONE HOUR</b> <b>25 YEARS</b> <b>25 YEARS</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>CEREBRAL THROMBOSIS</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>APRIL 20, 1981</b> , to <b>JUNE 27, 1981</b> , that (I) (we) last saw the deceased alive on <b>APRIL 20, 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Gordon S. Rosenberger, M.D.</b> DEGREE <b>MD</b>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>June 29, 1981</b>			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <b>Gordon S. Rosenberger, M.D.</b>			22f. ADDRESS <b>310 W. Montg. Ave; Rockville, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>July 1, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Rockville Montgomery Md.</b>				
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey Funeral Homes P/A</b> <b>300 W. Montgomery Ave., Rockville, Maryland</b>					25a. REC'D BY REGISTRAR <b>JUL 6 1981</b>		25b. REGISTRAR'S SIGNATURE <b>L. H. H. H.</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and no other event, within 72 hours after death.

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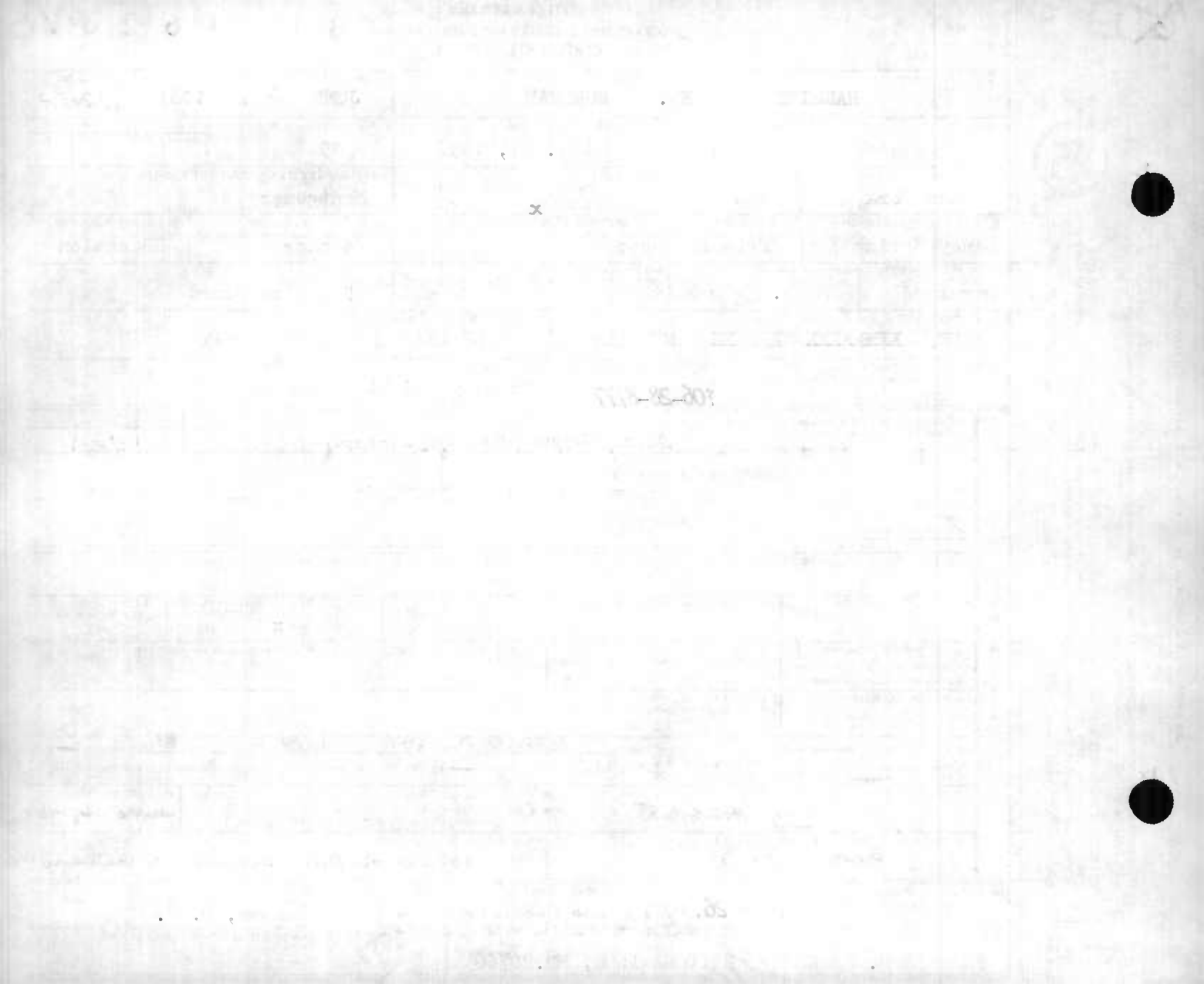
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 6 2 3 7	
1. FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) HARRIET N. BURNHAM			2a. DATE OF DEATH MONTH DAY YEAR JUNE 26 1981		2b. HOUR 12:15 A.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Nov. 21, 1891	6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS # UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Sandy Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Friends House		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY Education
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Mont.	13c. CITY OR TOWN Gaithersburg	
14. FATHER'S NAME FIRST MIDDLE LAST ELMER KENNEDY XXXXXXXX NEWELL			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LILLIAN METZ		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 106-28-8777	17. INFORMANT ADDRESS Dorothy Wright Same as # 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>years</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) <del>(the hospital)</del> attended the deceased from <u>September 17, 1980</u> to <u>June 6, 1981</u> , that (I) <del>(we)</del> lost saw the deceased alive on <u>March 25, 1981</u> , and that in (my) <del>last</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did not) view the body after death.					
22b. SIGNATURE <u>Barry Heels</u>		DEGREE MD		22c. DATE SIGNED June 26, 1981	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY HEELS		22e. ADDRESS 10620 GEORGETA AVENUE SILVER SPRING, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE JUNE 26, 1981	23c. NAME OF CEMETERY OR CREMATORY Lee Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D. C.
24. FUNERAL DIRECTOR NAME FRANCIS H. BARBER		ADDRESS LAYTONSVILLE, MD. 20760		25a. DATE FILED BY REGISTRAR JUN 29 1981	
		25b. REGISTRAR'S SIGNATURE			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 6 2 3 8			
1 - FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <i>ALICE Theresa Bush</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>6/17/81</i>		2b. HOUR <i>5 5<sup>2</sup> AM</i>	
3. SEX <i>female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>10 29 1904</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>76</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Ireland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery County MD</i>	
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <i>Holy Cross Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>home</i>	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Rockville</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME (TYPE OR PRINT) <i>Peter</i>		15. MOTHER'S MAIDEN NAME (TYPE OR PRINT) <i>Mabel Ohara Deady</i>		16. STREET ADDRESS <i>257 Congressional Lane</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. <i>212 547 54 00</i>		17. INFORMANT ADDRESS <i>Thomas J. McKeon 11213 Whisperwood Lne Rockville, Md. 20852</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Pneumonia</i> <i>1629</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Carcinoma of lung</i> (c) <i>Chronic obstructive pulmonary disease</i> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) <i>Chronic obstructive pulmonary disease</i>				18b. SOCIAL SECURITY NO. <i>212 547 54 00</i>		18c. TIME OF DEATH (HOUR, MINUTE, SECOND) <i>3 days</i> <i>4 mos</i>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION (CITY OR TOWN, COUNTY, STATE)			
22a. I certify that (1) (this hospital) attended the deceased from <i>Oct 6-16</i> , 19 <i>76</i> , to <i>6-17</i> , 19 <i>81</i> , that (1) (we) lost saw the deceased alive on <i>6-16</i> , 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Bernard H. Ostrow</i>				DEGREE		22c. DATE SIGNED <i>6-17-81</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>BERNARD H. OSTROW</i>				22e. ADDRESS <i>5225 Boks Hill Rd Bethesda, MD</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>6/19/81</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Woodlawn Cemetery</i>		23d. LOCATION (CITY OR TOWN, COUNTY) <i>Bronx New York</i>	
24. FUNERAL DIRECTOR'S NAME <i>Tyson Wheeler Funeral Home, Inc.</i>				25a. DATE REC'D BY REGISTRAR <i>JUN 23 1981</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	
1331 Rockville Pike Rockville, Maryland							

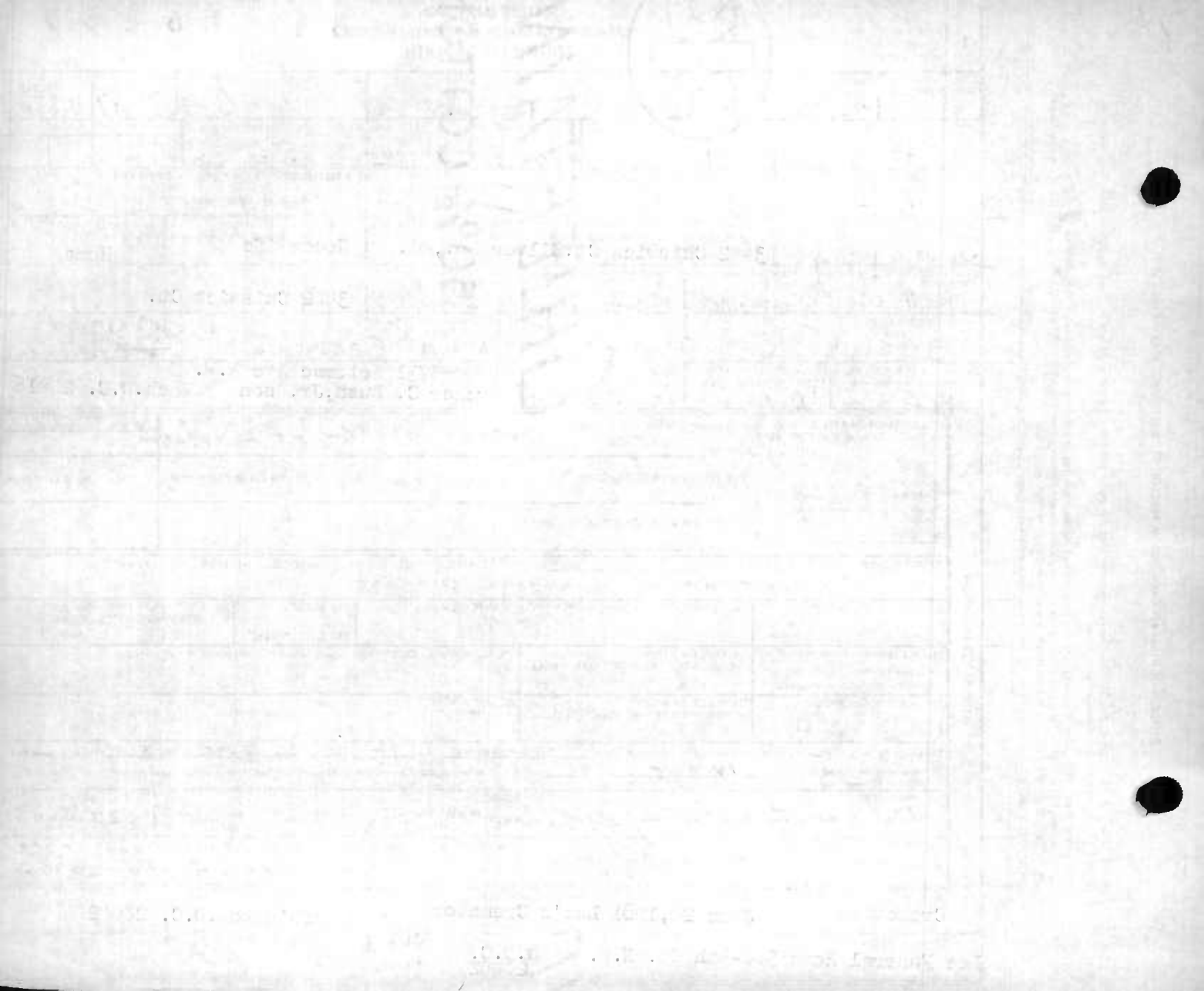


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Helen D. Bush			2a. DATE OF DEATH MONTH DAY YEAR 6 27 81				2b. HOUR 12 <sup>30</sup> P.M.		
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR April 20 1895		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. J.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3402 Chiswick Ct. Silver Sp., Md.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3402 Chiswick Ct.	
14. FATHER'S NAME FIRST MIDDLE LAST Justus W. Dobbins		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EMMA CAROLINE Dickinson Dobbins							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 147 36 0585		17. INFORMANT 3731 Potomac Ave. N.W. Archer C. Bush, Jr. son Wash. D.C. 20016					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Ca of Lymphatic system (Lymphosarcoma)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (b) <u>system (Lymphosarcoma)</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>6 months</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Hypertensive vascular disease</u>									
19a. DATE OF OPERATION 2		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <u>November 19 76</u> , to <u>26 June 19 81</u> , that (I) (we) last saw the deceased alive on <u>12 June 19 81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Dr. Alberto Rotsztein / M.D.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 27 Jun 81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Alberto Rotsztein, M.D.				22e. ADDRESS Leisure World Medical Center Silver Spring, Md 20905					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE June 28, 1981		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C. 20002			
24. FUNERAL DIRECTOR NAME Lee Funeral Home 300-4th St. N.E. Wash. D.C. 20002				25. REGISTRAR'S SIGNATURE JUL 1 1981		26. REGISTRAR'S SIGNATURE			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 6 2 4 0			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				7b. HOUR			
Josephine M. Byrnes				6/1/81				2:35 P.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. UNDER 1 YEAR		7. UNDER 24 HRS.	
Female		White		10/23/95		86 85 YES		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRED <input type="checkbox"/> NEVER MARRED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
PENNSYLVANIA		USA				Montgomery				MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Rockville		Collegewood Nursing Center		FILM INSPECTOR		MGM					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
MARYLAND		MONTGOMERY		SILVER SPRING		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		12036 MILTON STREET			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
JAMES MURPHY				MARGARET MURPHY							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.				17. INFORMANT			
NO				577-18-2254				NORA DOUGHERTY			
				SAME AS 13				DAUGHTER			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN CAUSE AND DEATH	
IMMEDIATE CAUSE (a) 4100										24 hr	
DUE TO, OR AS A CONSEQUENCE OF (b) Long-term heart disease										24 hr	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
Diabetes Mellitus											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
				HOUR A.M. MONTH DAY YEAR							
21d. INJURY OCCURRED				21e. PLACE OF INJURY				21f. LOCATION			
AT HOME <input type="checkbox"/> NOT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>				AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.				CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11 P.M. 1981 to June 1, 1981 that (I) (we) last saw the deceased alive on 5/31/81 and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
Paul Noone				MD				6/1/81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
Paul Noone											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		STATE	
BURIAL				6/4/81		MT. OLIVET CEMETERY		WASHINGTON, D. C.			
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
FRANCIS J. COLLINS						JUN 5 1981		Patrick McCreedy			
500 UNIVERSITY BLVD., W., SILVER SPRING, MD. 20901											

MEDICAL CERTIFICATION

BP

RECEIVED  
JAN 10 1900  
U.S. DEPT. OF AGRICULTURE  
WASHINGTON, D.C.

1. The first part of the report deals with the general conditions of the country during the year. It is found that the weather was generally favorable, and the crops were well advanced. The stock raising industry was also doing well, and the people were generally satisfied with the progress of the year.

2. The second part of the report deals with the various industries of the country. It is found that the mining industry was doing well, and the people were generally satisfied with the progress of the year. The manufacturing industry was also doing well, and the people were generally satisfied with the progress of the year.

3. The third part of the report deals with the various branches of the government. It is found that the various branches of the government were generally doing well, and the people were generally satisfied with the progress of the year.

4. The fourth part of the report deals with the various branches of the government. It is found that the various branches of the government were generally doing well, and the people were generally satisfied with the progress of the year.

5. The fifth part of the report deals with the various branches of the government. It is found that the various branches of the government were generally doing well, and the people were generally satisfied with the progress of the year.

6. The sixth part of the report deals with the various branches of the government. It is found that the various branches of the government were generally doing well, and the people were generally satisfied with the progress of the year.

7. The seventh part of the report deals with the various branches of the government. It is found that the various branches of the government were generally doing well, and the people were generally satisfied with the progress of the year.

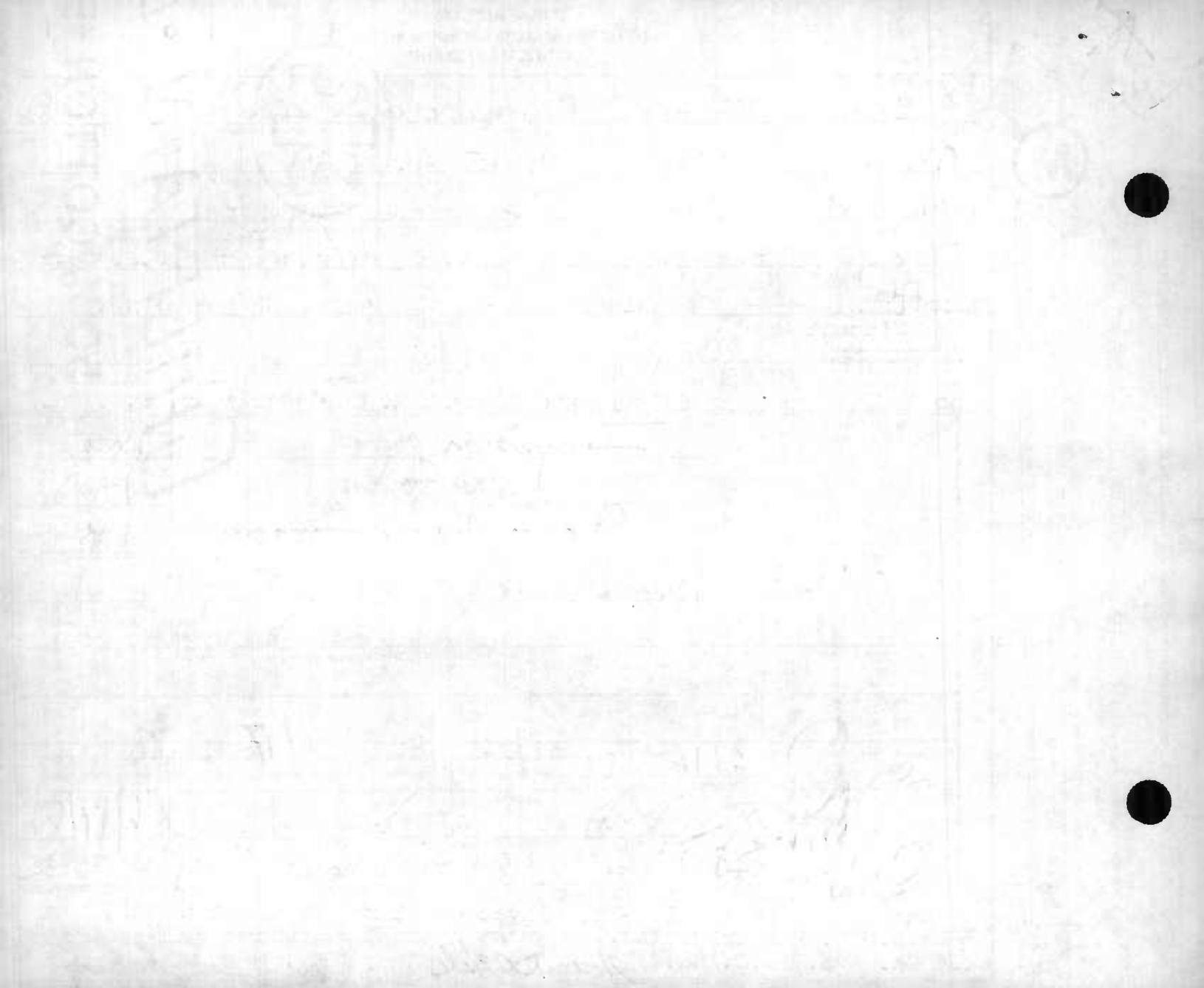
8. The eighth part of the report deals with the various branches of the government. It is found that the various branches of the government were generally doing well, and the people were generally satisfied with the progress of the year.

9. The ninth part of the report deals with the various branches of the government. It is found that the various branches of the government were generally doing well, and the people were generally satisfied with the progress of the year.

10. The tenth part of the report deals with the various branches of the government. It is found that the various branches of the government were generally doing well, and the people were generally satisfied with the progress of the year.









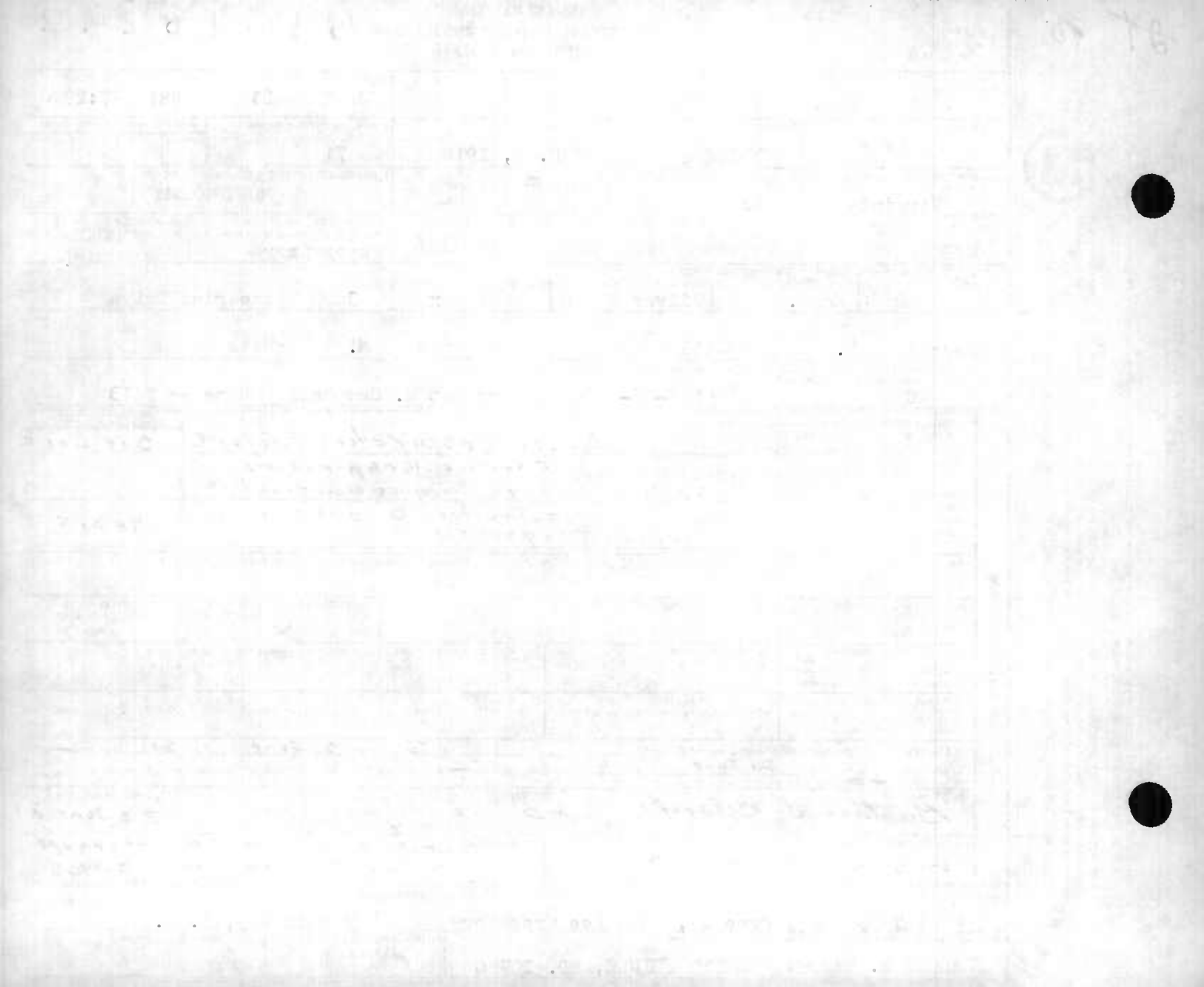
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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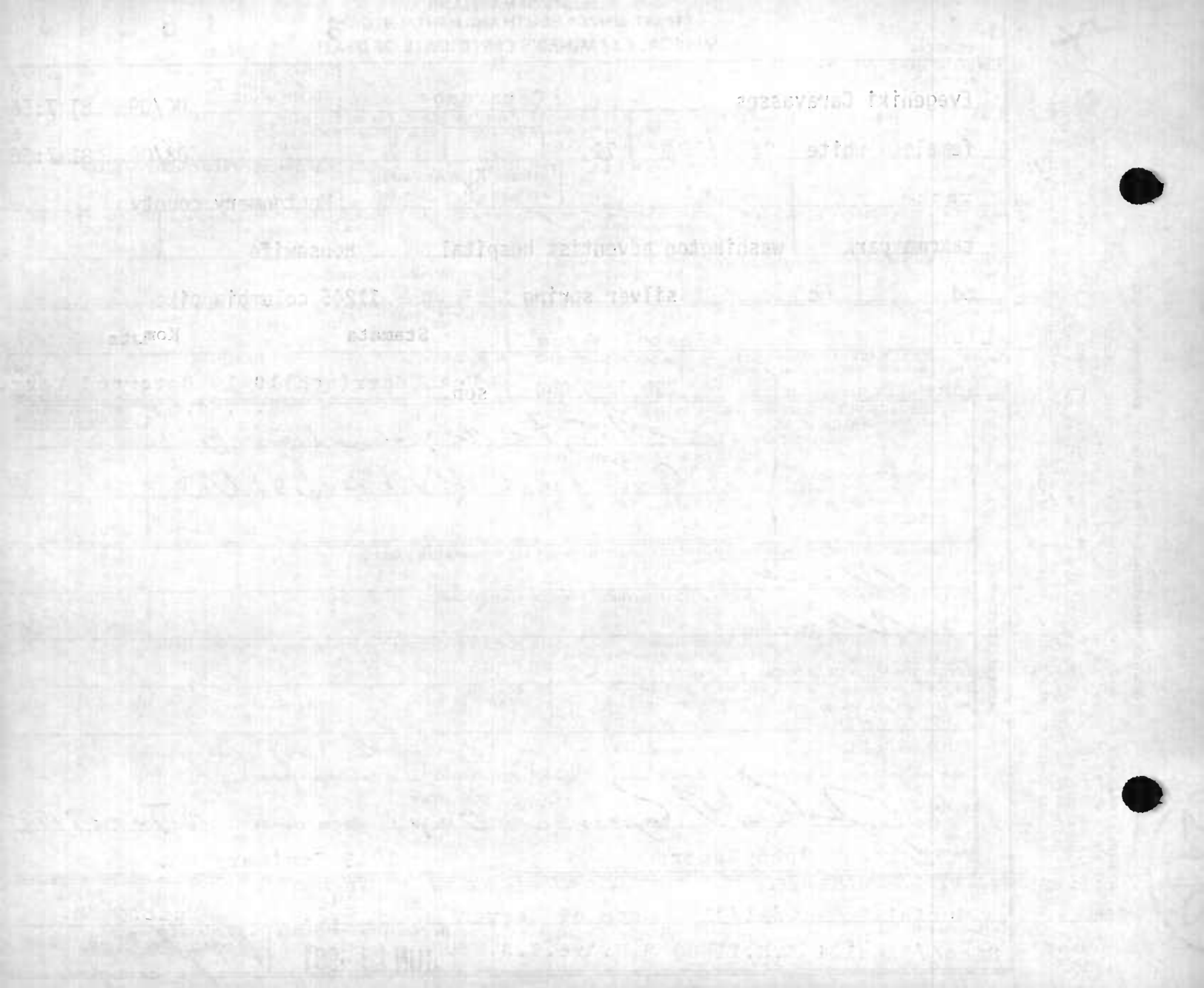
## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 6 2 4 2			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) EARL RUSSELL CAMPBELL				2a. DATE OF DEATH JUNE 21 1981		2b. HOUR 7:29 A M	
3 SEX Male		4 RACE WHITE		5 DATE OF BIRTH JAN. 6, 1910		6 AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10 CITY OR TOWN OF DEATH OLNEY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MONTGOMERY GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor		12b. KIND OF BUSINESS OR INDUSTRY COKE MANUFAC.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13a. STATE Maryland		13b. COUNTY Mont.		13c. CITY OR TOWN Silver Spring		13d. STREET ADDRESS 3600 Gleneagles Drive	
14 FATHER'S NAME FIRST MIDDLE LAST Russell H. Campbell				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret M. Hebets			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 012-07-1284		17 INFORMANT ADDRESS Margaret E. Campbell Same as # 13			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Respiratory Failure</u> <u>4912</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Respiratory Failure due to Chronic Obstructive</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>pulmonary Disease due to Chronic Bronchitis</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>One week</u> <u>Years</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>19 76</u> to <u>21 June</u> , 19 <u>81</u> , that (I) <del>last</del> saw the deceased alive on <u>21 June</u> , 19 <u>81</u> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>did not</del> (did not) view the body after death.							
22b. SIGNATURE <u>Gustavo S. Belaval</u> MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>22 June 81</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Gustavo S. Belaval</u>				22e. ADDRESS <u>Leisure World Medical Center</u> <u>Silver Spring, MD 20906</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>CREMATION</u>		23b. DATE <u>June 22, 1981</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lee Crematory</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Washington, D. C.</u>	
24 FUNERAL DIRECTOR NAME ADDRESS <u>FRANCIS H. BARBER</u> <u>LAYTONSVILLE, MD. 20760</u>				25a. DATE RECEIVED BY REGISTRAR <u>JUN 24 1981</u> 25b. REGISTRAR'S SIGNATURE			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 16243	
1. DECEASED NAME FIRST MIDDLE LAST <b>Eugeniki Caravasos</b>										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>06/09 19 81</b>	
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9/13/10</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>70</b> YRS.		IF UNDER 1 YR. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. <b>06/09 19 81</b>		2b. HOUR <b>7:50 a</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Greece</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery county</b> MD.			
10. CITY OR TOWN OF DEATH <b>takoma park</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>washington adventist hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>md</b>		13b. COUNTY <b>mc</b>		13c. CITY OR TOWN <b>silver spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>11245 columbia pike</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Niko Kostolambros</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Stamata Konsta</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>None</b>		16b. SOCIAL SECURITY NO. <b>233 52 8300B</b>		17. INFORMANT ADDRESS <b>Dean Carr(son) 10410 Gatewood Terr. S.S.Md.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>4291</b> IMMEDIATE CAUSE (a) <b>Acute Myocardial Dis.</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. } (b) <b>Chronic Myocardial Dis.</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>None</b>											
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>John Rogers</b>		TITLE (SPECIFY) <b>Dep.</b>		M.D. <b>Dep.</b> MEDICAL EXAMINER				DATE SIGNED <b>June 9, 1981</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>John Rogers</b>		ADDRESS <b>1919 Seminary Rd.</b>									
23b. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/11/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>S.S. Mont. Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Hines/Rinaldi</b>		ADDRESS <b>F.H. 11800 N.H. Ave. S.S. Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 11 1981</b>				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
1. FOR STATE REGISTRAR					7 1 1 6 2 4 4					
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					
FIRST MIDDLE LAST					MONTH DAY YEAR					
Mary E. Carrico.					JUNE 28 1981					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		
FEMALE		WHITE		MONTH DAY YEAR FEB. 19 1900		81 YRS		IF UNDER 24 HRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
VIRGINIA		U.S.A.				MONTGOMERY		MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
TAKOMA PARK		WASHINGTON ADVENTIST HOSPITAL				FEDERAL GOVT		G.A.O. (RET.)		
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
MARYLAND			MONTGOMERY		SILVER SPRING		YES <input type="checkbox"/> NO <input type="checkbox"/>		11397 COLUMBIA PKE APT. C-9	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST JAMES THORPE			FIRST MIDDLE LAST MATILDA ROBERTSON							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS					
NO			579-09-0663		DOROTHY E. DiBONA, (SAME AS 130a)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>plurist Effusion</u> 4149 DUE TO, OR AS A CONSEQUENCE OF (b) <u>congestive Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Heart Disease</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> 19 <u>65</u> , to <u>June 28</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>June 28</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		
<u>Boris Rabkin MD</u>								<u>June 29, 1981</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS							
BORIS RABKIN M.D.			1019 University Blvd East							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial		July 1, 1981		Oakdale Cemetery		Oakdale (Greenwich) Virginia				
24. FUNERAL DIRECTOR NAME			ADDRESS			DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Takoma Funeral Home, J. Rabkin			254 Carroll St NW			JUL 2 1981				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 6 2 4 5			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
FIRST MIDDLE LAST <b>JOHN CHAMPION</b>				MONTH DAY YEAR <b>June 29 1981</b>				2:30P M			
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>August 01, 1899</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>SOUTH CAROLINA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.					
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RAILROAD WORKER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>RAILROAD</b>			
13a. STATE <b>MARYLAND</b>		13b. CITY OR TOWN <b>P.G. MARYLAND PARK</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>5720 EAGLE ST.</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>WILL CHAMPION</b>				15. MOTHER'S MAIDEN NAME MIDDLE LAST <b>LUCINDA</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>709 12 4676</b>		17. INFORMANT ADDRESS <b>ELEANOR MCCOY DAUGHTER 5720 EAGLE ST.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA</b> <b>4370</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>ARTERIO SCLEROTIC CEREBRO VASCULAR DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 DAY</b> <b>2 YEARS</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (the deceased) attended the deceased from <b>JAN 1981</b> to <b>29 JUNE 1981</b> that (we) last saw the deceased alive on <b>29 JUNE 1981</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Walter E. Goetz MD</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>29 JUNE 81</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WALTER E. GOOZH MD</b>				22e. ADDRESS <b>2309 SHOREFIELD RD WHEATON MD</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>JUL 3, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HARMONY MEMORIAL</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>LANDOVER, MD</b>					
24. FUNERAL DIRECTOR <b>ALEXANDER S. POPE 2617 PENNSYLVANIA AVE S.W.</b>				25. DATE REC'D. BY REGISTRAR <b>7-9-81</b>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 6 2 4 6

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Anna S. Cheronis</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6-9-81</b>		2b. HOUR <b>6:39P.M.</b>						
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 20 1906</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Greece</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.					
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Potomac</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <b>11818 Rosalinda Drive</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Anastasios Spirou</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Agnes</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>195-30-1393</b>		17. INFORMANT son ADDRESS <b>11818 Rosalinda Dr. Andrew Kavounis/in law/ Potomac, Md. 20854</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adenocarcinoma @ breast</b> <b>1749</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <b>Bilateral lung, @ bronchial obstruction, bone metastasis. ASHD. Fem. Symp.</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from <b>8 June 1981</b> to <b>9 June 1981</b> , that (1) <del>was</del> last saw the deceased alive on <b>8 June 1981</b> , and that in (my) <del>her</del> opinion death occurred on the date and hour and from the causes stated above. (1) <del>was</del> (did) <del>not</del> view the body after death.											
22b. SIGNATURE <b>Donald E. Dillon MD</b>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>9 June 81</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Donald E. Dillon, MD</b>					22e. ADDRESS <b>18111 Prince Phillip Dr., Olney, Md. 20832</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>June 13, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oakland Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Warren Warren Pennsylvania</b>				
24. FUNERAL DIRECTOR NAME ADDRESS <b>Hines/Rinaldi F.H./ Silver Spring, Md.</b>					25a. DATE REC'D. BY REGISTRAR <b>JUN 11 1981</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>				



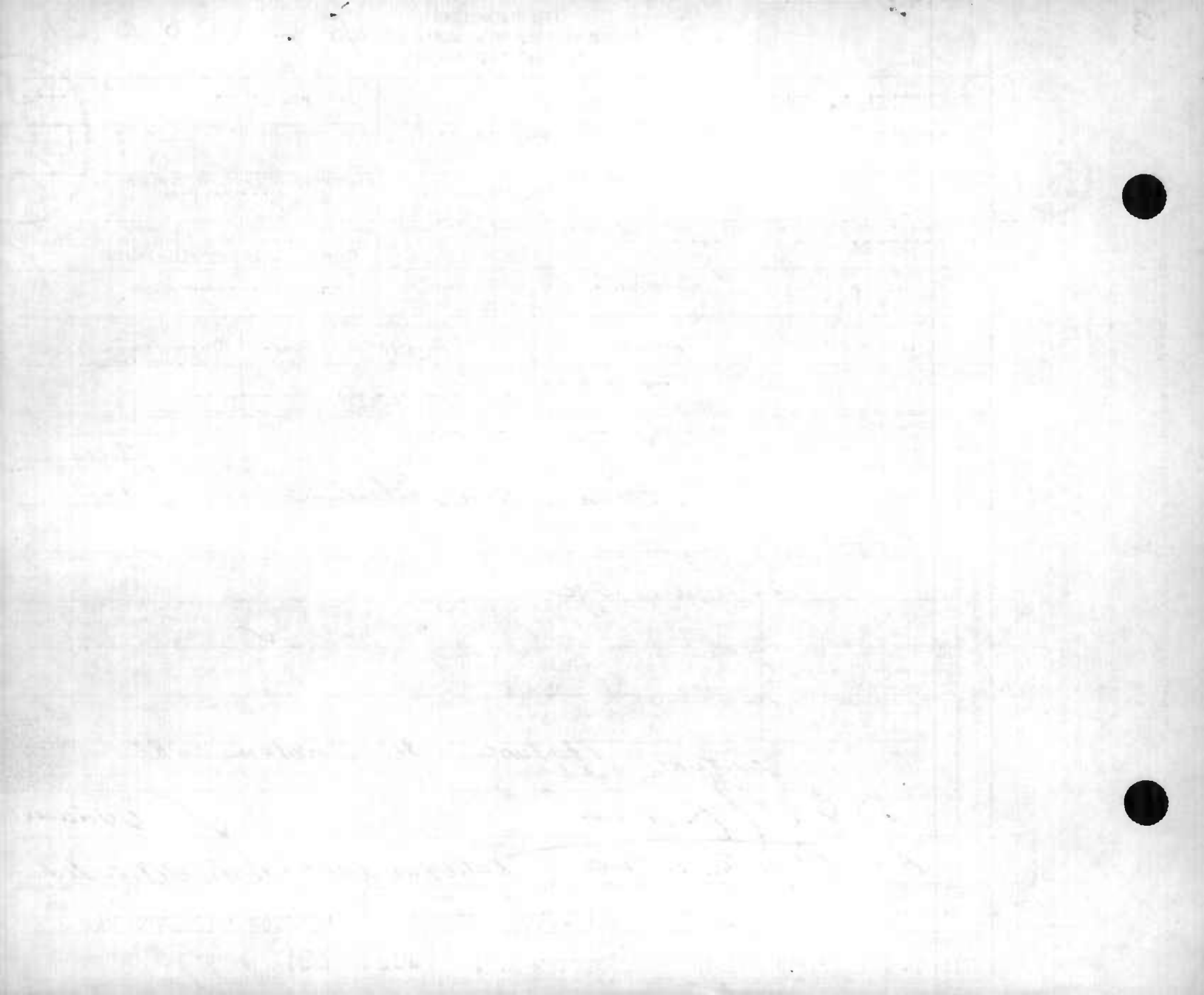
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 1 1 6 2 4 7			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ETHEL R. COLEMAN</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>JUN 24 81</b>		2b. HOUR <b>2215</b> M	
3 SEX <b>FEMALE</b>		4 RACE <b>NEGROID</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JAN 24 82</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>49</b> YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN CITY, GIVE STREET ADDRESS) <b>NNMC</b>		12a. USUAL OCCUPATION (TYPE OF WORK OR LAST OF WORKING LIFE) <b>Custodial Service</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>WASH D.C.</b> 13b. COUNTY				13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>414 WESTMINSTER ST.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JAMES E. CARTER</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>FANNIE MAE CARPENTER</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>579 34 7719</b>		17 INFORMANT ADDRESS <b>FLORENCE JACKSON SEE ITEM 13</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> <b>3 hrs</b>							
5850 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic Renal Failure</b> <b>3 hrs.</b>							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Advanced age</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>17 June 19 81</b> to <b>24 June 19 81</b> , that (I) (we) last saw the deceased alive on <b>24 JUNE 19 81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>B. C. FLORENCE DO</b> DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>24 June 81</b>	
22d. PHYSICIAN'S NAME (PRINT) <b>B. C. FLORENCE DO</b>				22e. ADDRESS <b>National Naval Medical Center</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>6-29-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>ARLINGTON ARLINGTON VA</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>JOHN T. RHINES FUNERAL HOME WASHINGTON D.C.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 7 1981</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Clarence C. Connolly</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>June 21, 1981</b>			2b. HOUR <b>6:00 AM</b>				
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 30, 1922</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>58</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County, MD.</b>				
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>12205 Connecticut Avenue</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Bricklayer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>12205 Connecticut Avenue</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harry T. Connolly</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Helen L. Downs</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) <b>WW 11 578 24 5189</b>		17. INFORMANT <b>Wife</b> ADDRESS <b>Minnie M. Connolly Same as item 13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b> <b>4960</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Severe COPD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>19 80</b> , to <b>June 21, 1981</b> , that (I) (we) lost saw the deceased alive on <b>6/20</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Carol L. Bender</b> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED <b>June 21, 1981</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Carol L. Bender, M.D.</b>					22e. ADDRESS <b>11510 Old Georgetown Rd. Bethesda, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>June 24, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Memorial</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Rockville, Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>ROBERT A. PUMPHREY FUNERAL HOMES, P.A., ROCKVILLE, MARYLAND</b>					25a. DATE REC'D. BY REGISTRAR <b>JUN 29 1981</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be associated within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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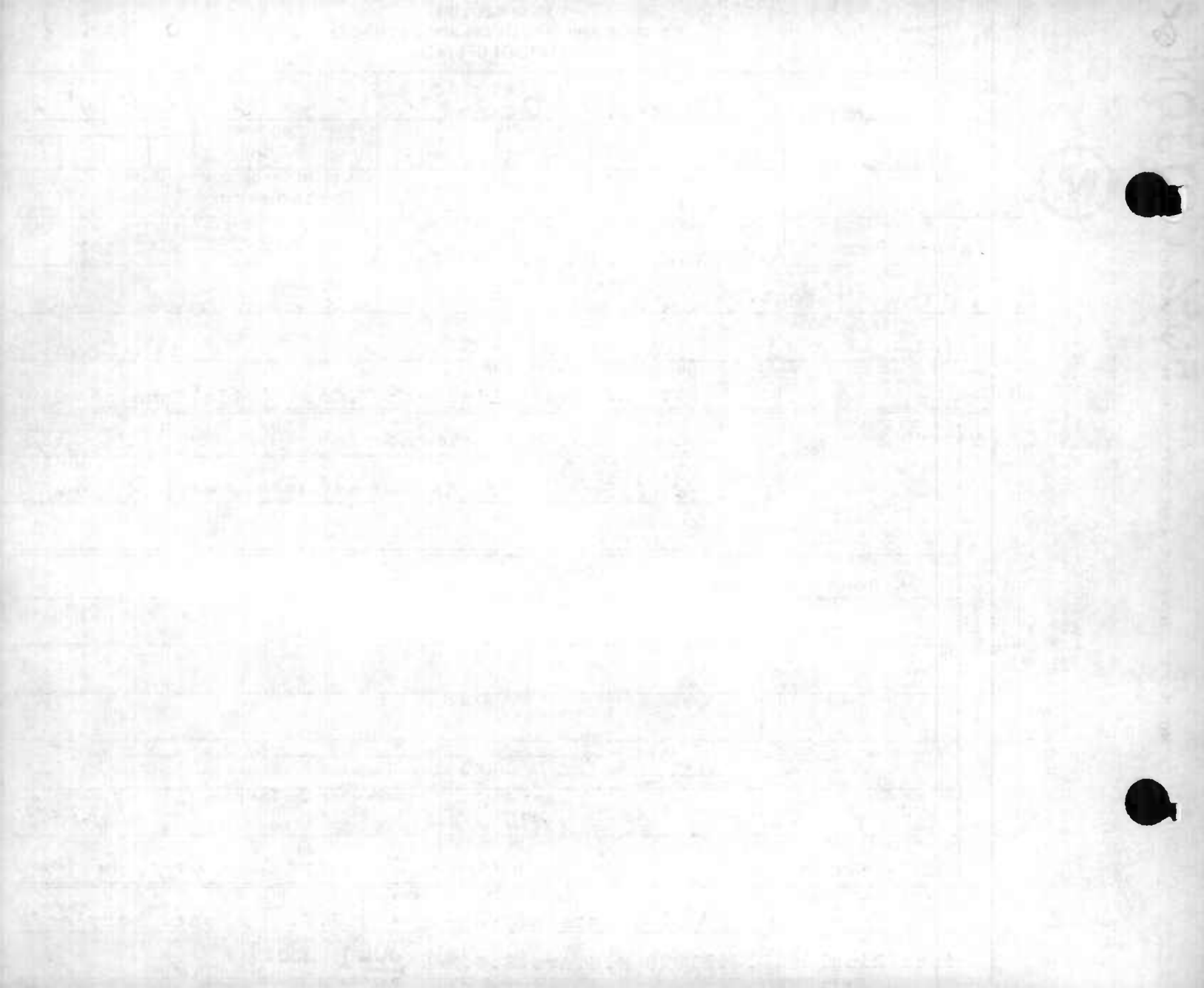
1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Henry George Coon Jr.</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>6 27 81</u>		2b. HOUR <u>9<sup>55</sup> A.M.</u>				
3. SEX <u>male</u>		4. RACE <u>white</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>9 1 41</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>39</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Washington D.C.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery</u> MD.			
10. CITY OR TOWN OF DEATH <u>Takoma Park</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Washington Adventist Hospital</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Ceco Corp.</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Manager</u>	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>md</u> 13b. COUNTY <u>Mont.</u> 13c. CITY OR TOWN <u>Silver Spring</u> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <u>308 South Waterford Rd</u>									
14. FATHER'S NAME FIRST MIDDLE LAST <u>Henry G. Coon Sr.</u>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Frances McCormick</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <u>None</u>		16b. SOCIAL SECURITY NO. <u>579 54 5005</u>		17. INFORMANT ADDRESS <u>Elizabeth F. Coon (Wife) Same as above</u>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gram negative Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Undifferentiated mediastinal Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>1649</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 mo.</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a) <u>lung pneumonia</u>									
19a. DATE OF OPERATION <u>—</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>19</u> P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>April 6/27</u> 19 <u>81</u> , to <u>6/27</u> 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>6/27</u> 19 <u>81</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (and poll) view the body after death.									
22b. SIGNATURE <u>Peter B. Sherer</u>				DEGREE <u>MD</u> ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>6/27/81</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>PETER SHERER MD</u>				22e. ADDRESS <u>1109 Spring St. #610 Silver Spring md. 20910</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>6/30/81</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>S.S. Mont. Maryland</u>			
24. FUNERAL DIRECTOR NAME <u>Hines/Rinaldi</u>				F.H. <u>11800</u> ADDRESS <u>N.H. Ave. S.S. Md.</u>		25a. DATE REC'D. BY REGISTRAR <u>JUL 1 1981</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified after

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>SAMUEL ARON COOPER</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>June 25, 1981</b>			2b. HOUR <b>12:30<sup>a</sup></b>		
3 SEX <b>Male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Apr. 16, 1892</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>89</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Russia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.				
10. CITY OR TOWN OF DEATH <b>Wheaton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Builder (Ret)</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>		
13a. STATE <b>Maryland</b>					13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Wheaton</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Aron Krupnick</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bossie (unknown)</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. <b>WW I</b>		17. INFORMANT ADDRESS <b>Wheaton, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> 1534 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial Failure</b> (c) <b>Carcinoma of Cecum with Metastases</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ( )										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) <input checked="" type="checkbox"/> (s) hospital attended the deceased from <b>July 19 53</b> to <b>June 19 81</b> , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on <b>June 24, 19 81</b> , and that in (my) <input checked="" type="checkbox"/> (we) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Robert L. Krichmar</i>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>6-25-81</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROBERT L. KRICHMAR, M.D.</b>					22e. ADDRESS <b>7733 Alaska Ave. NW, Wash., D.C.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>6-28-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King David Mem. Cn.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Falls Church, Virginia</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Danzansky-Goldberg Rockville, Md.</b> <b>Mem. Chapels 1170 Rockville Pike</b>										

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR		CERTIFICATE OF DEATH		REG. NO.	
1. DECEASED NAME (LAST, FIRST, MIDDLE) Also known as: Annita Copeland Annita Copeland Ann Copeland		2. DATE OF BIRTH MONTH DAY YEAR April 25, 1914		2a. DATE OF DEATH MONTH DAY YEAR June 14, 1981	
3. SEX Female		4. RACE White		2b. HOUR P. 11:30 M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	
10. CITY OR TOWN OF DEATH Potomac		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10001 South Glen Road		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
13a. STATE Maryland		13b. COUNTY Montgomery		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Office Mngr.	
14. FATHER'S NAME FIRST MIDDLE LAST Louis M. Corrado		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary F. Buono		12b. KIND OF BUSINESS OR (TYPE OF WORK FOR MOST OF WORKING LIFE) News magazine	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 577-44-2764		17. INFORMANT (son) Henry H. Copeland-Dr. Sil. Spr. Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of colon with metastatic foci</u> 1539 DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>4/19</u> 19 <u>81</u> to <u>6/14</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>6/14</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) see the body after death.					
22b. SIGNATURE <u>Myron L. Lenkin</u> MD		22c. PHYSICIAN'S NAME (TYPE OR PRINT) Myron L. Lenkin, MD		22d. ADDRESS 2309 Shorefield Rd. Wheaton, Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-17-81		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven	
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. 8434 Ga. Ave., S.S. Md.		25a. DATE REC'D. BY REGISTRAR JUN 18 1981		25b. REGISTRAR'S SIGNATURE <u>Anthony M. Brady</u>	

MEDICAL CERTIFICATION



*[Faint, mostly illegible handwritten text covering the majority of the page. Some words like "Dear" and "Yours" are faintly visible.]*

*[Handwritten signature or name at the bottom center of the page.]*

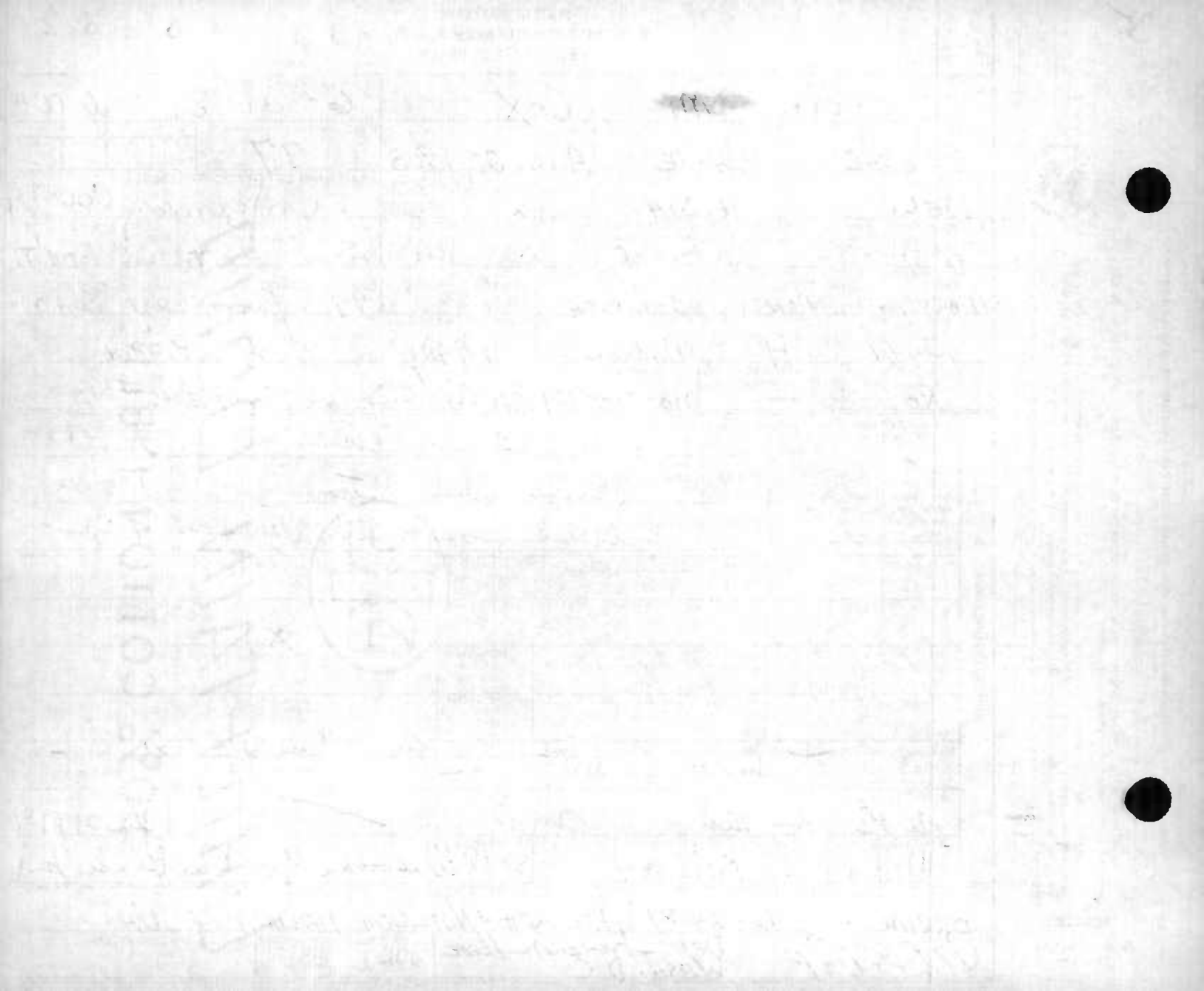
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

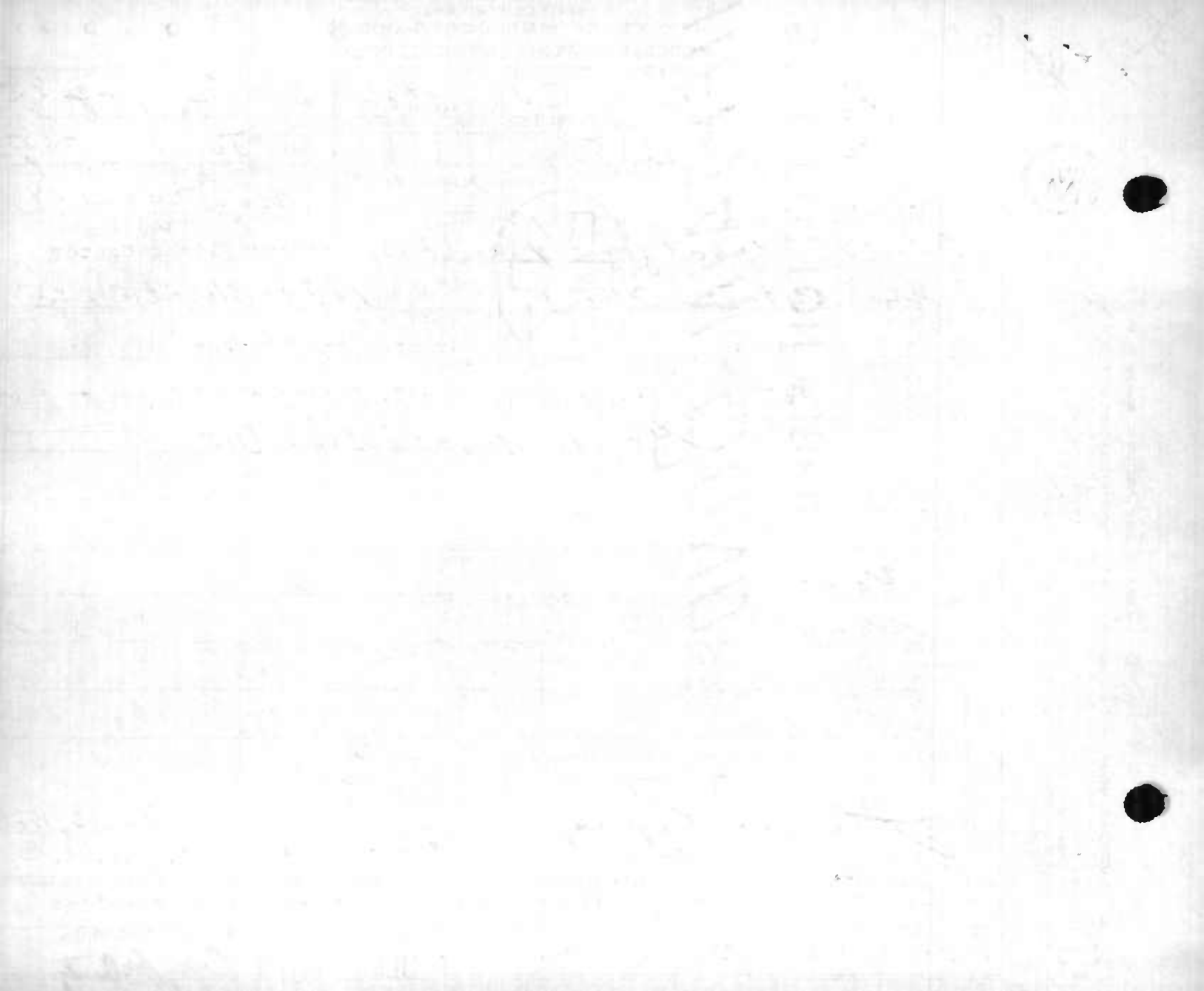
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 6 2 5 2			
1- FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
EDITH M. COX				6-21-81			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
FEMALE		WHITE		AUG. 20, 1903		77 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
DEL.		U.S.A.				Montgomery County MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BETHESDA		Suburban Hospital		Admin. Ass't.		D.C. Gov't.	
13a. STATE				13b. CITY OR TOWN		13c. STREET ADDRESS	
MARYLAND				MONT.		BETHESDA	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
JOHN H. MARVEL				MARY ANN PIPPIN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT	
No				218-03-4201		PHYLLIS C. SMINK SAME AS #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) 4332 Cardiac Pulmonary Arrest							Immediate
DUE TO, OR AS A CONSEQUENCE OF (b) Brain Stem Stroke							1 week
DUE TO, OR AS A CONSEQUENCE OF (c) Vertebral Basilar Artery Occlusion							1 yr
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from July 1980, to June 21, 1981, that (I) (we) last saw the deceased alive on June 20, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
William H. Killian				M.D.		June 21, 1981	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
William H. Killian				8218 Wisconsin Ave Bethesda Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		6-24-81		ARLINGTON NAT'L CEM		ARLINGTON VA.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
DEVOL FUNERAL HOME		JUL 1 1981		[Signature]			
WASH. D.C.							





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 16253			
1. DECEASED NAME (TYPE OR PRINT) <b>Edward C. Cranston</b>						7a. DATE KNOWN OF DEATH ESTIMATED <b>June 5, 1981</b>		7b. HOUR <b>8:44</b>		7c. DATE PRONOUNCED DEAD <b>June 5, 1981</b>			
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept 9, 26 54</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>54</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7d. HOUR <b>8:44</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wash. D.C.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.				
10. CITY OR TOWN OF DEATH <b>Olney</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery Gen'l Hosp</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Goddard Flight Center</b>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD</b>			13b. COUNTY <b>Mont.</b>			13c. CITY OR TOWN <b>Olney</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS <b>18801 Bloomfield Rd.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>James J. Cranston</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret Ann Vierkorn</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>			(IF YES, GIVE WAR OR DATES) <b>WWII</b>			16b. SOCIAL SECURITY NO. <b>578 34 5930</b>			17. INFORMANT ADDRESS <b>Mary B. Cranston (Wife) Same as Above</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Dis.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>None</b>													
19a. DATE OF OPERATION <b>None</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE <b>John S. Rogers</b>				TITLE (SPECIFY) M.D. <b>Dep</b>				MEDICAL EXAMINER ADDRESS <b>1919 Seminary Rd. S.S.Md.</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers</b>				DATE SIGNED <b>June 5, 1981</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>6/9/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Family Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Conway, North Carolina</b>					
24. FUNERAL DIRECTOR NAME <b>Hines/Rinaldi F.H. 11800 N.H.Ave. S.S.Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>JUN 11 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Lucy A. Burt</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8 1 1 6 2 5 4		
FOR 1 - STATE REGISTRAR					REG. NO.		
1 DECEASED NAME (TYPE OR PRINT) Edna G. Crawford			2a DATE OF DEATH June 14 1981		2b. HOUR 4:10 A.M.		
3 SEX Female		4 RACE White		5 DATE OF BIRTH 7 8 89		6 AGE (IN YEARS LAST BIRTHDAY) 91 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10 CITY OR TOWN OF DEATH Wheaton, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Randolph Hills Nursing Home		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CASHIER		12b KIND OF BUSINESS OR INDUSTRY BOOKKEEPER	
13a STATE Md.			13b COUNTY Montgomery		13c CITY OR TOWN Wheaton		
14 FATHER'S NAME FIRST MIDDLE LAST George W. OREM			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Hutchins				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 577-22-4001		17 INFORMANT I. F. OREM		ADDRESS SAME AS 13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic cardiovascular disease</u> <u>4292</u> DUE TO, OR AS A CONSEQUENCE OF <u>disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>diabetes mellitus</u>							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <u>5/15 19 81</u> to <u>6/14 19 81</u> , that (I) (we) last saw the deceased alive on <u>6/14 19 81</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.							
22b SIGNATURE <u>Barry N. Rosenbaum, M.D.</u>				DEGREE		22c DATE SIGNED <u>6/14/81</u>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) BARRY N. ROSENBAUM				22e ADDRESS 3720 FARRAGUT AVE. KENSINGTON, MD. 20795			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b DATE 6/16/81		23c NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		23d LOCATION SUTLAND	
24 FUNERAL DIRECTOR NAME FRANCIS J. COLLINS				25a DATE REC'D BY REGISTRAR JUN 15 1981			
25b ADDRESS 500 UNIV. BLVD. W., SILVER SPRING, MD. 20901				25c SIGNATURE <u>Francis J. Collins</u>			



Items #10a-22a Film G557 7/31/81rc STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 6 2 5 5

1. DECEASED NAME (TYPE OR PRINT)			FIRST INA			MIDDLE J.			LAST CURLES			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR			2b. HOUR								
3 SEX female			4 RACE white			5. DATE OF BIRTH MONTH DAY YEAR Oct 9 1942			6. AGE (IN YEARS) LAST BIRTHDAY 38s.			IF UNDER 1 YR. MONTHS DAYS HOURS MIN			7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 6-15-81			7d. HOUR 1:45 P.M.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D. C.			7b. CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County						MD								
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Institute of Health Parking lot						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY											
13a. STATE Md.			13b. COUNTY PG			13c. CITY OR TOWN Cheverly			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 3420 63 Avenue											
14. FATHER'S NAME FIRST MIDDLE LAST Homer L. Revis, Sr.						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pauline Davis																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No						16b. SOCIAL SECURITY NO. 214-42-3768						17. INFORMANT Same as Above											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Flurazepam intoxication</u> 7503 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):																							
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. ? 19 81						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2) self/ingested											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) parking lot						21f. LOCATION STREET CITY OR TOWN COUNTY STATE NIH Parking Lot Bethesda Montg. Co. Md.											
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE <i>Margie A. Korell</i>						TITLE (SPECIFY) Assistant						DATE SIGNED 6-16-81											
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.						ADDRESS 111 Penn Street																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial						23b. DATE 6-19-81						23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.						23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, P.G., Maryland					
24. FUNERAL DIRECTOR NAME Robt E Wilhelm						4308 Suitland Rd., Suitland, Md.						25a. DATE REC'D. BY REGISTRAR JUN 22 1981						25b. REGISTRAR'S SIGNATURE <i>Robert Wilhelm</i>					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

10-25-2

20-25-2

10-25-2

10-25-2

10-25-2

10-25-2

10-25-2

10-25-2

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										81	16256
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary Patricia Fairall Daniels										20. DATE KNOWN OF DEATH ESTIMATED 6/22 19 81	21. HOUR A. M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 28, 1938	6. AGE (IN YEARS) (LAST BIRTHDAY) 43 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS.	7. DATE PRONOUNCED DEAD 6/22 19 81	22. HOUR A. M.				
2a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.					
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) secretary		12b. KIND OF BUSINESS OR INDUSTRY legal			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Prince Georges		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7981 New Riggs Road, #208			
14. FATHER'S NAME FIRST MIDDLE LAST Patterson McCeney Fairall				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary <del>James</del> Jessie Reece							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 216 36 0040		17. INFORMANT ADDRESS 8963 Oliver Court Patterson Fairall, Jr Manassas, Va					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Left subdural hematoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>fall</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>convulsive disorder.</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11 days 11 days Years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): None											
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR xxx 1/11 19 81		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Fell in parking lot.					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Parking lot		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 15th Avenue, Hyattsville, Pr. Geo., Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. Deputy				MEDICAL EXAMINER DATE SIGNED 1/5/82			
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.				ADDRESS 1919 Seminary Road Silver Spring, Montgomery, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 24, 1981		23c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Laurel, Maryland			
24. FUNERAL DIRECTOR NAME Donaldson Funeral Home, Laurel, Md ADDRESS						25a. DATE REC'D. BY REGISTRAR FEB 16 1982		25b. REGISTRAR'S SIGNATURE 			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/funeral permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	1	1	6	2	5	7			
1. FOR STATE REGISTRAR										REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)										2a. DATE OF DEATH				2b. HOUR					
SIDNEY M. DARRAGH										June 24, '81				12:05 PM					
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE			7. IF UNDER 1 YEAR		7. IF UNDER 24 HRS					
Female			White			Oct. 29, 1897			83 YRS			MONTHS		DAYS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH										
Ireland			U S A						Montgomery County MD.										
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Bethesda			Suburban Hospital							Bookkeeper Contractor									
13a. STATE										13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS					
Md. Montgomery										Bethesda		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		201 Russell Ave.					
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME									
Samuel MOORE										Annie BAXTER									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)										16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
no										015 03 4616		Mr. William M. Darragh 4046 Crescent Rd. Ellicott City							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:										APPROPRIATE PERIOD BETWEEN ONSET AND DEATH									
IMMEDIATE CAUSE (a) PERITONITIS										3 days									
5570 DUE TO, OR AS A CONSEQUENCE OF (b) HANGRENE - Small										1 week									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										DUE TO, OR AS A CONSEQUENCE OF (c) INTESTINAL Intestini									
										2 days									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION (ENTER IN PART 19)										Obstruction									
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
6/19/81										Intestinal Obstruction			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
										HOUR A.M. MONTH DAY YEAR									
21d. INJURY OCCURRED										21e. PLACE OF INJURY			21f. LOCATION						
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>										[AT HOME STREET FACTORY OFFICE FARM, ETC.]			CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE			DEGREE			22c. DATE SIGNED			
										Thos. G. Ward MD			ATTENDING PHYSICIAN MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			6/24/81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS									
Thos. G. Ward										6116 Robt. A. Hood, Bethesda									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION			CITY OR TOWN		COUNTY		STATE				
Burial			June 26, 1981		Balto. National			Balto.			Balto.		Md.		Md.				
24. FUNERAL DIRECTOR										25a. DATE REC'D. BY REGISTRAR							25b. REGISTRAR'S SIGNATURE		
G. Truman Schwab 5151 Balto. National Pike Balto. Md. 21229										JUN 29 1981							[Signature]		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

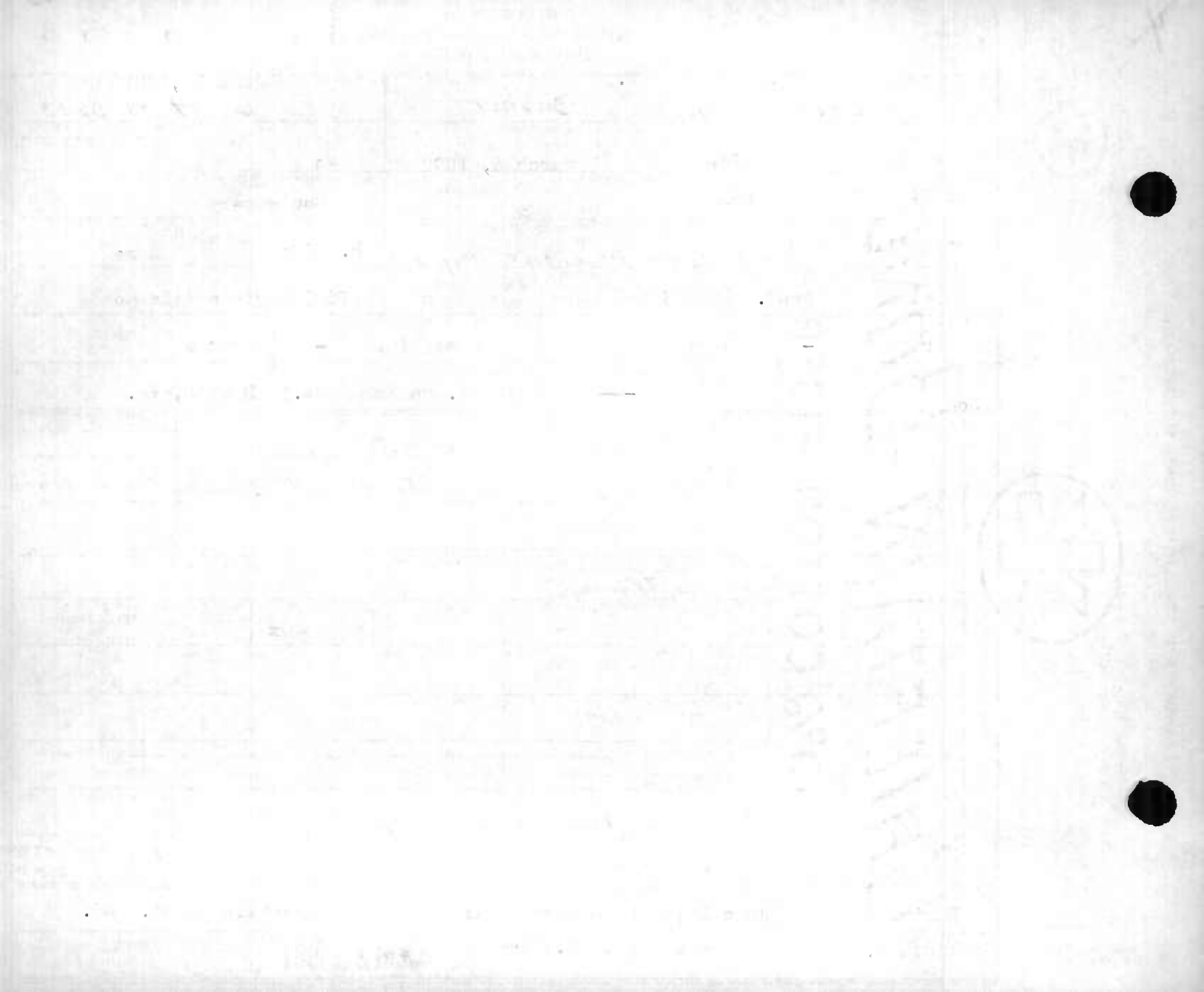
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Lena W. Dasher</b>			2a. DATE OF DEATH <b>JUNE 24, 1981</b>		2b. HOUR <b>6 24 81 0813 M</b>		
3. SEX <b>Female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 6, 1892</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Shady Grove Adventist Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>H. Wife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Mont.</b>		13c. CITY OR TOWN <b>Gaithersburg</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frank - Wagner</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Josephine - Trumbo</b>		13e. STREET ADDRESS <b>17607 Laytonsville Road</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT ADDRESS <b>Elva R. Huffman Rt. 1 Dayton, Va.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> <b>4140</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Severe Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Many years</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Aortic Stenosis</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Michael A. Bolognese</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Michael A. Bolognese</b>		22e. ADDRESS <b>19261 Montgomery Village Ave Gaithersburg, Md. 20878</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>June 26, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Laytonsville</b>		23d. LOCATION (CITY OR TOWN) COUNTY STATE <b>Laytonsville Mont. Md.</b>	
24. FUNERAL DIRECTOR <b>FRANCIS H. BARBER</b>				LAYTONSVILLE, MD. 20760		25a. DATE REC'D. BY REGISTRAR <b>JUN 29 1981</b>	
						25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 16259	
1. DECEASED NAME (TYPE OR PRINT) <b>Thomas A. Davidson</b>		2a. DATE KNOWN OF DEATH <b>June 28, 1981</b>		2b. MONTH DAY YEAR <b>10 28 81</b>	
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH <b>APRIL 12, 1901</b>	6. AGE (IN YEARS) <b>80</b> YRS.	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	2c. DATE PRONOUNCED DEAD <b>June 28, 1981</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>Olney</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Mont. General Hosp</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CHIEF MECHANIC</b>	
13a. STATE <b>MD</b>		13b. COUNTY <b>Mont.</b>		13c. CITY OR TOWN <b>Spr.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>WILLIAM DAVIDSON</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CARRIE B. HAYES</b>		16. SOCIAL SECURITY NO. <b>577-05-0411</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>577-05-0411</b>		17. INFORMANT <b>DAUGHTER MARGARET LIPSCOMB</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> 4291 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>DUE TO, OR AS A CONSEQUENCE OF</b> (c) <b>DUE TO, OR AS A CONSEQUENCE OF</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>None</b>					
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>John S. Rogers</b>		TITLE (SPECIFY) <b>M.D.</b>		DATE SIGNED <b>June 28, 1981</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>JOHN S. ROGERS</b>		ADDRESS <b>1919 SEMINARY ROAD, SILVER SPRING, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>7/1/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FOREST LAWN CEMETERY</b>	
23d. LOCATION CITY OR TOWN <b>NORFOLK</b>		COUNTY <b>VIRGINIA</b>		STATE	
24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 30 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Francis J. Collins</b>	
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 1 1 6 2 6 0	
1- FOR STATE REGISTRAR				CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Margaret L. Delphey				2a. DATE OF DEATH MONTH DAY YEAR 6 3 81				2b. HOUR 1 A.M.			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR FEB. 24, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO. MD.					
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NATIONAL LUTHERAN HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY NONE			
13a. STATE MARYLAND		13b. COUNTY PRINCE GEO.		13c. CITY OR TOWN MT. RAINIER		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4700- 30th STREET			
14. FATHER'S NAME FIRST MIDDLE LAST DAVID O. HOFFMAN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST VIOLA E. SCHAEFFER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NONE		17. INFORMANT ADDRESS SILVER SPRING, MD. REV. DR. RICHARD REICHARD-9701-VEIRS DR.,							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dehydration</u> 4379 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Paralytic Illness</u> (c) <u>Cerebro-Vascular Insufficiency 10 yrs.</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days 5 days 10 yrs.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Diabetes Mellitus</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from <u>6-22</u> 19 <u>71</u> to <u>6-3</u> 19 <u>81</u> that (I) <del>was</del> lost saw the deceased alive on <u>6-2</u> 19 <u>81</u> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (If) <del>possible</del> (did not) view the body after death.											
22b. SIGNATURE <u>Harold F. McCann</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6-3-81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. HAROLD F. McCANN						22e. ADDRESS 9701-VEIRS DRIVE., ROCKVILLE, MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JUNE 5, 1981		23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE FREDERICK, MARYLAND					
24. FUNERAL DIRECTOR NAME HYSONG FUNERAL HOME - 1300- N STREET, NW						25. DATE REC'D. BY REGISTRAR JUN 12 1981		25b. REGISTRAR'S SIGNATURE			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 1 1 6 2 6 1			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>BYRON CLARK DENNY</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>6 18 81</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 27, 1907</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penna.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Shaw Chase Nursing &amp; Convalescent Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Water Planning Analyst; US Gov't.</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>---</b>		13b. COUNTY <b>DC</b>		13c. CITY OR TOWN <b>Washington, DC</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William A. Denny</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Hannah -- Morris</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			
16b. SOCIAL SECURITY NO (YES, GIVE WAR OR DATES) <b>---</b>		17. INFORMANT <b>Emily P. Denny, Same address as # 13.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebrovascular &amp; Brain (left)</b> <b>1919</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) <del>this hospital</del> attended the deceased from <b>March</b> , 19 <b>79</b> , to <b>June 17</b> , 19 <b>81</b> , that (I) <del>(we)</del> lost saw the deceased alive on <b>June 17</b> , 19 <b>81</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) <del>not</del> view the body after death.							
22b. SIGNATURE <b>George A. Boinis M.D.</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>June 17 1981</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>George A. Boinis</b>				22e. ADDRESS <b>5410 Conn. Ave., NW, Washington, D.C.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>6/19/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, Maryland</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave., NW, Washington, D.C. 20016</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 22 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Henry McCreary</b>	

• W. H. Rouse Ball, 1869-1944, English mathematician and statistician.

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 1 1 6 2 6 2			
1. FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) WILLIAM V DEUTERMANN SR.				2a. DATE OF DEATH 06 12 81		2b. HOUR 23 <sup>20</sup> P M	
3 SEX Male		4 RACE White		5 DATE OF BIRTH Aug. 9, 1900		6 AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10 CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Naval Officer		12b. KIND OF BUSINESS OR INDUSTRY U.S. Navy	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 7004 Arandale Road	
14 FATHER'S NAME William X. Deuterman		15. MOTHER'S MAIDEN NAME Emma - Ward					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO WII & Korean 579-52-1128		17 INFORMANT ADDRESS William V. Deuterman, Jr - Address same as #13.			
11 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FATAL ARRHYTHMIA 4140 DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC HEART DIS DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 HRS 10 YRS.							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 6/9/81 19 to 6/12/81 19, that (I) (we) lost saw the deceased alive on 6/12/81 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (I) (we) did not view the body after death.							
22b. SIGNATURE Henry C. Scruggs, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/13/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Henry C. Scruggs, M.D.				22e. ADDRESS 5413 W. Cedar Lane - Bethesda, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 16, 1981		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Ft. Myer, Virginia	
24 FUNERAL DIRECTOR NAME Jos. Gawler's Sons, Inc. - 5130 Wisc. Ave., Wash, D.C.				25a. DATE REC'D. BY REGISTRAR JUN 17 1981		25b. REGISTRAR'S SIGNATURE	



ED HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1- FOR STATE REGISTRAR					8 1 1 6 2 6 3				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
ANDRE S. DONALD					6 30 81 7 <sup>15</sup> A M				
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Male		Black		Sept. 20, 1939		41		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Wash., D.C.		USA				montgomery MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Takoma Park		Washington Adventist Hosp.				Electrician			
13a. STATE					13b. COUNTY		13c. CITY OR TOWN		
Maryland					Lanham		5502 Ruxton Drive		
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
Samuel Donald					Alice C. Proctor				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
yes					578 48 8916		Mrs. Alice C. Parker-mother-		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>intestinal obstruction</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1850 } DUE TO OR AS A CONSEQUENCE OF (b) <u>mitral valve prolapse</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
			P.M. 19						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>6/17</u> 19 <u>81</u> , to <u>6/30</u> 19 <u>81</u> , that (I) (we) lost <u>saw the deceased give on above (I/we) did (did not) view the body after death.</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated									
22b. SIGNATURE					DEGREE			22c. DATE SIGNED	
<u>[Signature]</u>								6/30/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
23a. BURIAL, CREMATION, OR OTHER (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		
Burial			July 2, 1981		Harmony Memorial Park		Landover, Md.		
24. FUNERAL DIRECTOR NAME					25a. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Stewart Funeral Home-4001 Benning Road, N.E.					JUL 1 1981				



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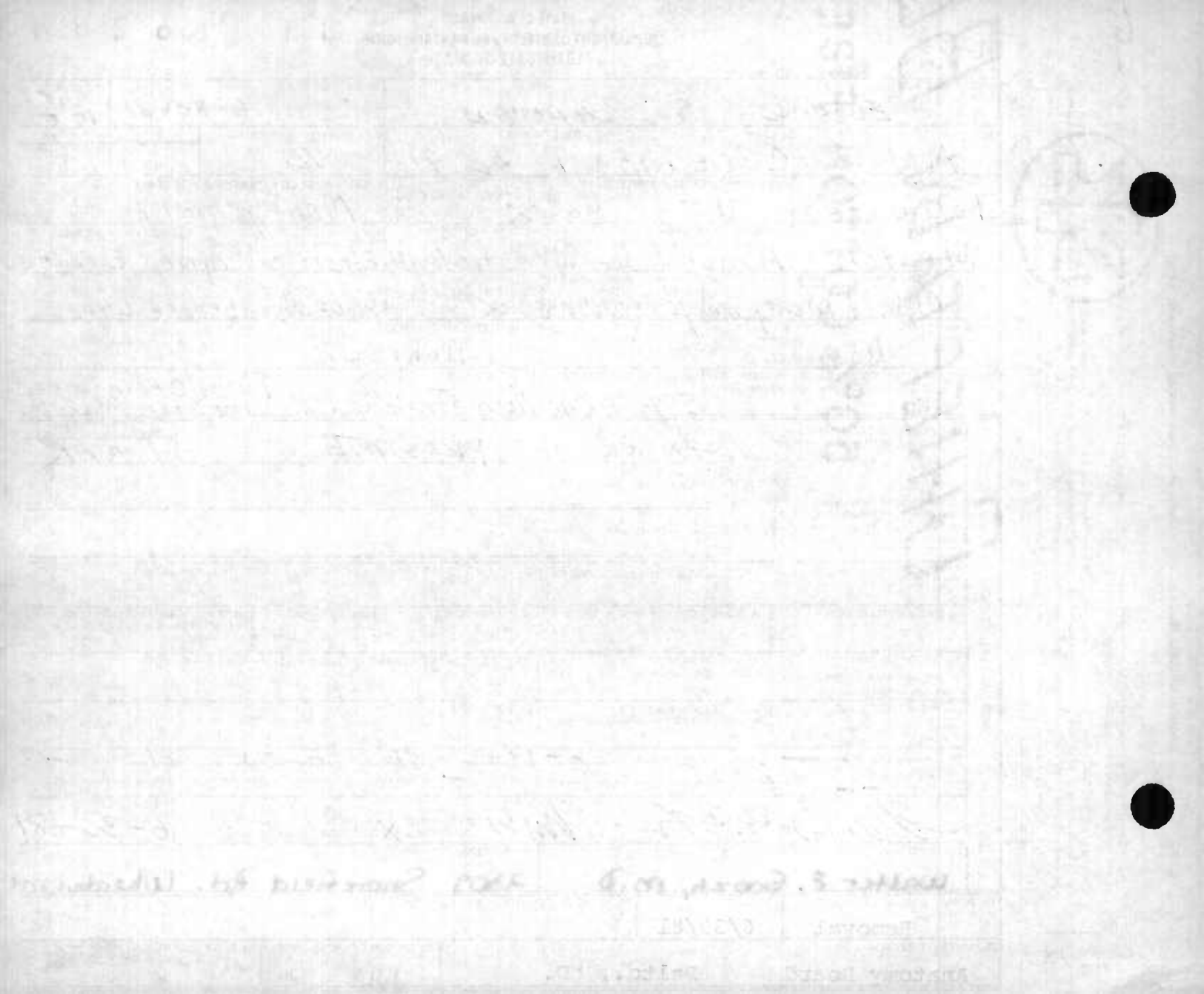
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 1 1 6 2 6 4			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Eugene S DONOVAN</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>6-30-81</b>		2b. HOUR <b>10<sup>15</sup> A.M.</b>	
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 80 91</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>90</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Delaware</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Wheaton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Manor Care Wheaton HqH</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Electrical Engineer Electric</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Cherry Chase</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS <b>8603 Woodbrooke Lane</b>		14. FATHER'S NAME FIRST MIDDLE LAST <b>Unknown</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>	
16b. SOCIAL SECURITY NO. <b>577-58-8716</b>		17. INFORMANT <b>Norma Fraley RNDN</b>		ADDRESS <b>11901 Georgia Ave Wheaton, Md 20902</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>1850 IMMEDIATE CAUSE (a) CANCER OF PROSTATE</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <b>6-19-1981</b> to <b>6-30-1981</b> , that (I) (we) last saw the deceased alive on <b>6-25-1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <b>Walter E. Gooch, M.D.</b> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22c. DATE SIGNED <b>6-30-81</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Walter E. Gooch, M.D.</b>		22e. ADDRESS <b>3309 Shorefield Rd. Wheaton, Md.</b>		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>	
23b. DATE <b>6/30/81</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b> ADDRESS <b>Balto., MD.</b>	
25a. DATE REC'D. BY REGISTRAR <b>JUL 0 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Norma Fraley</b>		25c. REGISTRAR'S NAME		25d. REGISTRAR'S ADDRESS	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 8116265					
1. FOR STATE REGISTRAR					2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Margaret B. DUNCAN					June 4 1981 4:00P M					
2. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Feb. 19 1915		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 8. IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kansas		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. STATE Virginia					13b. CITY OR TOWN Fairfax		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS 823 Neal Drive	
14. FATHER'S NAME FIRST MIDDLE LAST Frank E. Bonney					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude Briatch					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 548 36 5243		17. INFORMANT ADDRESS James W. Duncan See item 13						
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY / CARDIAC ARREST								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) METASTATIC OAT CELL LUNG CANCER										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from May 13 19 81, to June 4 19 81, that (I/we) last saw the deceased alive on June 4 19 81, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did/did not) view the body after death.										
22b. SIGNATURE Robert Chyn MD				DEGREE MD		22c. DATE SIGNED June 5, 1981		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		
22e. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT CHYN MD				22d. ADDRESS National Naval Medical Center, Bethesda, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 9 81		23c. NAME OF CEMETERY OR CREMATORY West Point Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE West Point MD				
24. FUNERAL DIRECTOR NAME Demaine Funeral Homes, Inc., Alex. Va. 22314				25a. DATE REC'D. BY REGISTRAR JUN 11 1981		25b. REGISTRAR'S SIGNATURE				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1- FOR STATE REGISTRAR					8 1 1 6 2 6 6				
CERTIFICATE OF DEATH					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>Stephen FRANCIS Dunn</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>6-10-81</b>			2b. HOUR <b>7<sup>35</sup> PM</b>	
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 24 1908</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>attorney</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Montgomery</b> 13c. CITY OR TOWN <b>Silver Spring</b> 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					13e. STREET ADDRESS <b>3552 Chiswick Court</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>Stephen F. Dunn</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth C. Hand</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>--</b>		17. INFORMANT ADDRESS <b>Eleanor Dunn same as 13e</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO-RESPIRATORY FAILURE</b> <b>5621</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>GASTRO-INTESTINAL BLEEDING</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>DIVERTICULAR DISEASE</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 DYS</b> <b>1 MO</b> <b>10 YRS</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>① COLON RESECTION ② INTESTINAL OBSTRUCTION</b>									
19a. DATE OF OPERATION <b>5/13/81</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>LOWER G-I. BLEEDING</b>			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the physician) attended the deceased from <b>5/12/81</b> , 19____, to <b>6/10/81</b> , 19____, that (I) (over) lost saw the deceased alive on <b>6/10/81</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>William H. Dickson</b>					DEGREE <b>M.D.</b>			22c. DATE SIGNED <b>6/11/81</b>	
22d. PHYSICIAN'S NAME (Type in full) <b>Wm H. Dickson</b>					22e. ADDRESS <b>11125 ROCKVILLE PIKE ROCKVILLE MD.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>6/13/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Memorial Park</b>			23d. LOCATION CITY <b>Rockville</b> , COUNTY <b>Maryland</b>	
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home, Inc.</b> <b>1331 Rockville Pike Rockville, Md.</b>					25a. DATE REC'D. BY REGISTRAR <b>JUN 15 1981</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

BP

1351 Rockville, Md. Inc.

Barry 6/13/81

Bartholomew Memorial Park, Rockville, Maryland

W. H. D. Jones

W. H. D. Jones

6/13/81

6/13/81

6/13/81

2/13/81

Lower C-1, ROCKVILLE

X

① Colon Reservoir ② Intermittent Construction

DIVISION OF HIGHWAYS

CHARTERED INTERSTATE HIGHWAY

CHARTERED INTERSTATE HIGHWAY

no

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358-09-3585 Eleanor Dunn name as 135

Stephen

W.

Dunn

Elizabeth

W.

Hand

Maryland

Montgomery Silver Spring X

3525 Chiswick Court

retired

attorney

Pennsylvania

US

white

II

SA

1900

75



## CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Harold E. Dutton, Sr.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>June 30, 1981</b>		2b. HOUR <b>8:35AM</b>	
3 SEX <b>Male</b>		4 RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 1, 1906</b>		
6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b>		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.				
10. CITY OR TOWN OF DEATH <b>Olney</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>		
12b. KIND OF BUSINESS OR INDUSTRY <b>W.S.S.C.</b>		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Md.</b> 13b. COUNTY <b>Howard</b> 13c. CITY OR TOWN <b>Woodbine</b>				
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>6937 Eden Mill Road</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>Clarence Dutton</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Catherine Christian</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Myrtle Dutton (wife) same as #13</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hodgkin's Disease</b> <b>3019</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <b>4. Bone Marrow, lymph node involvement. Pancytopenia Hypersplenism Splenomegaly</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE		
22. I certify that (I) (this hospital) attended the deceased from <b>June 19, 79</b> to <b>30 June 19, 81</b> , that (I) <del>lost</del> <b>saw</b> the deceased alive on <b>29 June 19, 81</b> , and that in (my) <del>last</del> <b>own</b> opinion death occurred on the date and hour and from the causes stated above, (I) <del>have</del> <b>did</b> <del>not view</del> the body after death.						
22a. SIGNATURE <b>Donald E. Dillon MD</b>		DEGREE		22c. DATE SIGNED <b>30 June 81</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Donald E. Dillon, M.D.</b>		22e. ADDRESS <b>1511 Pr Philip Dr Olney, Md 20832</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7-3-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Crest Lawn Mem. Gardens</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Marriottsville, Howard, Md.</b>		24. FUNERAL DIRECTOR NAME <b>George R. Snowden</b>				
24b. ADDRESS <b>246 N. Washington Street Rockville, Md. 20850</b>		25. DATE RECEIVED BY REGISTRAR <b>7-3-81</b>				
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		25c. REGISTRAR'S NAME <b>[Signature]</b>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

George T. Snowden  
Rockville, Md. 20850

246 N. Washington Street

7-3-83

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Great Linn. Hous. Rentals, Inc., Howard, Md.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
FIRST MIDDLE LAST <b>Williston Lamar Dye, Sr.</b>					MONTH DAY YEAR <b>June 27, 1981</b>				
3. SEX <b>Male</b>					2b. HOUR P. <b>2:14 P.</b>				
4. RACE <b>Caucasian</b>					2c. MONTH DAY MIN. <b>75</b>				
5. DATE OF BIRTH MONTH DAY YEAR <b>June 13, 1906</b>					6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>75</b>				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>California</b>					7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>				
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.				
10. CITY OR TOWN OF DEATH <b>Bethesda,</b>					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>National Naval Medical Cntr</b>				
12a. USUAL OCCUPATION (GIVE WORK FOR MOST OF WORKING LIFE) <b>Investment Broker</b>					12b. KIND OF BUSINESS OR INDUSTRY <b>Securities</b>				
13a. STATE <b>Maryland</b>					13b. COUNTY <b>Montgomery</b>				
13c. CITY OR TOWN <b>Bethesda</b>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>Leon Lamar Dye</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lillian S. Bray</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>					16b. SOCIAL SECURITY NO. <b>1929-1959</b>				
17. INFORMANT <b>Margaret S. Dye</b>					17a. ADDRESS <b>9709 Bellevue Drive Bethesda, Md. 20014</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ATHEROSCLEROTIC CORONARY ARTERY</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CONGESTIVE HEART FAILURE</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION									
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									
20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>									
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>									
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)									
21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <b>24 JUN 81</b> , 19 <b>81</b> , to <b>27 JUN</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>27 JUN</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Carl H June</b> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>									
22c. DATE SIGNED <b>28 JUN 81</b>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. CARL JUNE LT. MSC USN.</b>									
22e. ADDRESS <b>NATNAVMEDCEN BETHESDA MD.</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>									
23b. DATE <b>July 1, 1981</b>									
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>									
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington Virginia</b>									
24. FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland</b>									
25a. DATE REC'D. BY REGISTRAR <b>JUL 1 - 1981</b>									
25b. REGISTRAR'S SIGNATURE <b>Robert A. Pumphrey</b>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 1 1 6 2 6 9			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>FIRST RICHARD MIDDLE EATON LAST EATON</b> <b>RICHARD Eaton</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>6-1-81</b>		2b. HOUR <b>3 p M</b>	
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>10 8 1991</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Illinois</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10 CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>5408 Burling Road</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Broadcaster</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Radio</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b> 13b. COUNTY <b>Montgomery</b> 13c. CITY OR TOWN <b>Bethesda</b>				14. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		15. STREET ADDRESS <b>5408 Burling Road</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Daniel Eaton</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Maude (Unknown)</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>578-28-5666</b>		17. INFORMANT ADDRESS <b>Elsa Eaton, Wife. Same as item 913.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>1919</b> <b>Glucoblastoma metastasizing</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 months</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Myocardial infarction secondary to coronary disease with</b>							
19a. DATE OF OPERATION <b>Dec 81</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Brain tumor</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>July 50</b> to <b>6/1</b> 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>5/31</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Horbeal Wachter</b>				DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input type="checkbox"/>		22c. DATE SIGNED <b>6/1/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Horbeal Wachter</b>				22e. ADDRESS <b>1800 Eye St NW Washington D.C.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/4/1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington D.C.</b>	
24. FUNERAL DIRECTOR NAME <b>Joseph Gawler's Sons Inc.</b>				24b. ADDRESS <b>5130 Wisc. Ave., N.W. Wash., D.C.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 5 1981</b>	
				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



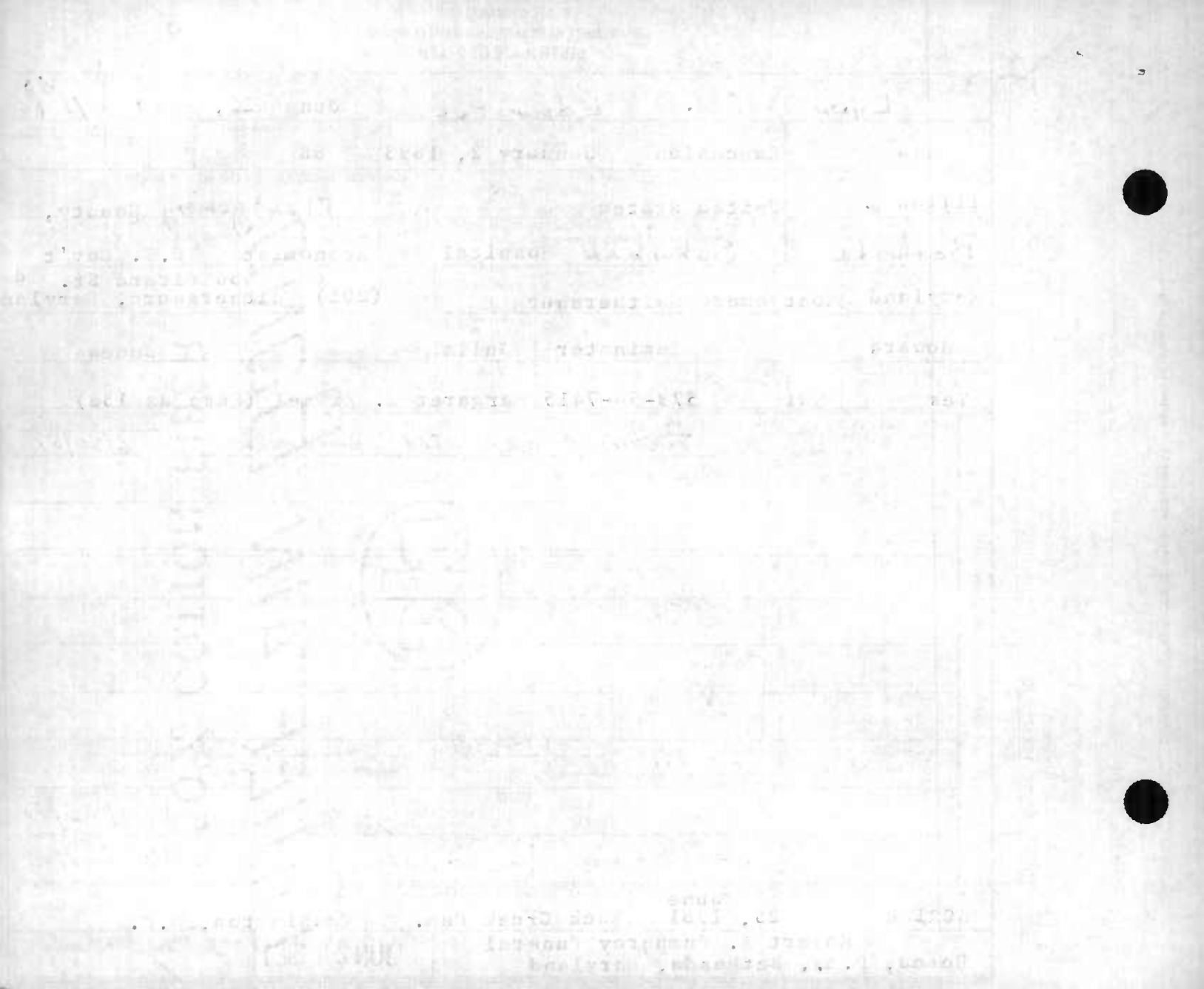
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	1	1	6	2	7	0	
1- FOR STATE REGISTRAR										REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>LYNN R. Edminster</b>										2a. DATE OF DEATH MONTH DAY YEAR <b>June 21, 1981</b>				2b. HOUR <b>11 PM</b>			
3. SEX <b>Male</b>			4. RACE <b>Caucasian</b>			5. DATE OF BIRTH MONTH DAY YEAR <b>January 2, 1893</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b>			IF UNDER 1 YEAR MONTHS DAYS <b>YRS.</b>		IF UNDER 24 HRS. HOURS MIN. <b>YRS.</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Illinois</b>			7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County, MD.</b>								
10. CITY OR TOWN OF DEATH <b>Bethesda</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Economist</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't</b>					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>										13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Gaithersburg</b>		13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e. STREET ADDRESS <b>450 Girard St. (201) Gaithersburg, Maryland</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Howard Edminster</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Julia Jones</b>												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>					16b. SOCIAL SECURITY NO. <b>WWI</b>		17. INFORMANT ADDRESS <b>Margaret E. Kimmel (Same as 13e)</b>										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal aspirated pneumonia</b> <b>5070</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6/20/81</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) <b>---</b>											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>---</b>			21f. LOCATION STREET <b>---</b>		CITY OR TOWN <b>---</b>		COUNTY <b>---</b>		STATE <b>---</b>					
22a. I certify that (I) (this hospital) attended the deceased from <b>6/20/81</b> 19 to <b>6/21/81</b> 19, that (I) (we) last saw the deceased alive on <b>6/21/81</b> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE 					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED <b>6/22/81</b>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>050TH CEKAGUL MD</b>					22e. ADDRESS <b>7415 Arlington Rd, Bethesda, MD</b>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>June 25, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cem.</b>			23d. LOCATION CITY OR TOWN COUNTY <b>Washington, D.C.</b>									
24. FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey</b>					ADDRESS <b>Homes, P.A., Bethesda, Maryland</b>			25a. DATE REC'D. BY REGISTRAR <b>JUN 29 1981</b>		25b. REGISTRAR'S SIGNATURE 							





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. **Cleared by Dr. Rogers, By phone June 11, 1981**

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

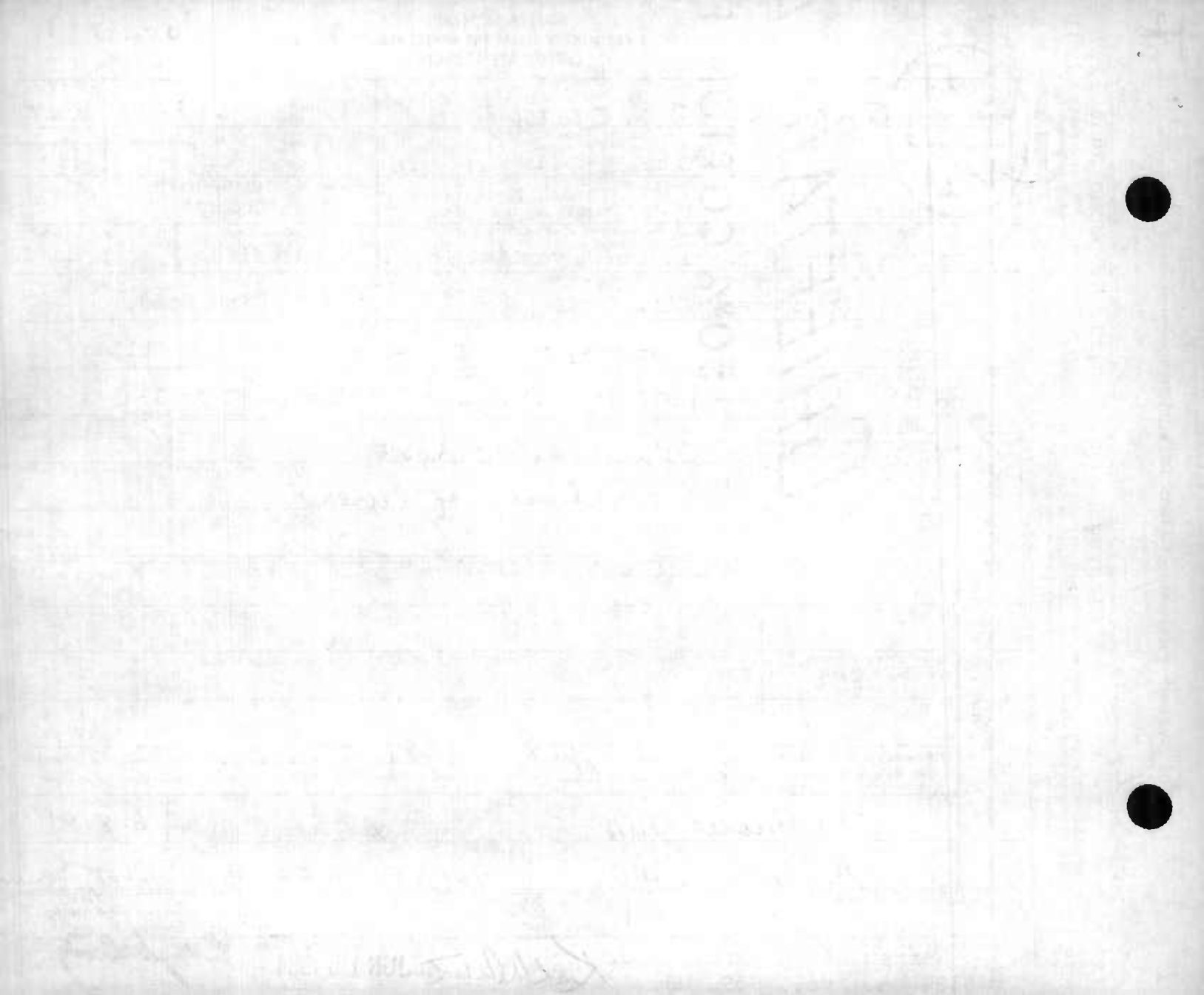
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP  
DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		6-8-81		10:45 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS (LAST BIRTHDAY))	
Female		White		MONTH DAY YEAR 12 21 26		54 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Washington, DC		USA				Montgomery MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Takoma Park		Washington Adventist Hosp.		Housewife		own home	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland		Montgomery		Sil. Spring		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
Louis		Florence Cullen		no		577-34-1750	
17. INFORMANT		ADDRESS		17. INFORMANT (husband)		ADDRESS	
John C. Elsele		- (same as 13e)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 5715 DUE TO, OR AS A CONSEQUENCE OF (b) <u>cirrhosis of liver</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>6-8-81</u> to <u>June 6, 1981</u> , that (I) (we) last saw the deceased alive on <u>6-8-81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
M Snow MD				6-8-81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
M SNOW MD		9013 FLOWER AVE SILVER SPRING					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN	
Burial		6-12-81		Gate of Heaven		Sil. Spring Montgomery Md.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR			
Warner E. Pumphrey, Inc.		JUN 15 1981					
8434 Ga. Ave., S.S. Md.							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the Registrar with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR					8 1 1 6 2 7 2				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
Emmy Eisenstadt					6-5-81				
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE		7b. HOUR	
FEMALE		Wht		10 31 94		86 YRS		10 55 PM	
7a. BIRTHPLACE		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED		9 BALTIMORE CITY OR COUNTY OF DEATH			
GERMANY		U.S.A.		NEVER MARRIED		Montgomery Co.		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY			
Takoma Park		Washington Adventist Hosp.		Housewife		Own Home			
13a. STATE					13b. COUNTY				
MD					Montgomery				
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
Max Arnhelm					Unknown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?					16b. SOCIAL SECURITY NO.				
No					017-12-9364				
17. INFORMANT					ADDRESS				
Michael Gordon-Attorney					7051 Carroll Ave.				
18. CAUSE OF DEATH									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) cardiac arrest									
4100									
DUE TO, OR AS A CONSEQUENCE OF									
(b) arterio-sclerotic heart disease									
DUE TO, OR AS A CONSEQUENCE OF									
(c) acute inferior & anterior septal infarct 13 days									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION									
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									
20a. AUTOPSY?									
YES <input type="checkbox"/> NO <input type="checkbox"/>									
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>									
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH									
(IF EITHER, NOTIFY MEDICAL EXAMINER)									
21b. TIME OF INJURY									
HOUR A.M. MONTH DAY YEAR									
P.M. 19									
21c. HOW INJURY OCCURRED									
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED									
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>									
21e. PLACE OF INJURY									
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)									
21f. LOCATION									
CITY OR TOWN COUNTY STATE									
22a. I certify that (1) (this hospital) attended the deceased from 6/5 1981, to 6/6 1981, that (1) (last) saw the deceased alive on 6/5 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did not) view the body after death.									
22b. SIGNATURE									
F. W. BRENNWALD MD									
22c. ADDRESS									
831 University Blvd E, Silver Spring, MD									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)									
F. W. BRENNWALD									
23a. BURIAL, CREMATION, REMOVAL									
REMOVAL									
23b. DATE									
6-8-81									
23c. NAME OF CEMETERY OR CREMATORY									
GEORGETOWN MEDICAL SCHOOL									
23d. LOCATION									
CITY OR TOWN COUNTY STATE									
WASHINGTON D.C.									
24. FUNERAL DIRECTOR									
NAME METROPOLITAN FUNERAL SERVICE									
5517 VINE ST. ALEXANDRIA, VA.									
25a. DATE REC'D. BY REGISTRAR									
JUN 12 1981									
25b. REGISTRAR'S SIGNATURE									
[Signature]									

7



10 0.7-11-0300 Michael Gordon - V. 1000000

1000000 1000000 1000000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1 DECEASED NAME (TYPE OR PRINT) <b>Olga M. Ellis</b>					2a DATE OF DEATH MONTH DAY YEAR <b>6-21-81</b>					2b HOUR <b>8 P.M.</b>
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>Sept. 27, 1913</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>67</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.				
10 CITY OR TOWN OF DEATH <b>Silver Spring</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>Maryland</b>		13b COUNTY <b>P.G.</b>		13c CITY OR TOWN <b>Hyattsville</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>4817 69th. Place</b>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>James Lewis Mavars</b>					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Martha Ann Williamson</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>			16b SOCIAL SECURITY NO. <b>577-05-5613</b>		17 INFORMANT ADDRESS <b>716 N. Fillmore St. Arlington, Virginia</b> <b>Diane M. Garrison</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiomyopathy arrest</b> 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>congestive cardiomyopathy</b> (c) <b>atherosclerosis</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b> <b>1 year</b>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE <b>(6/9/81)</b>						
22a I certify that (I) (this hospital) attended the deceased from <b>6/21/81</b> 19____, to <b>6/21/81</b> 19____, that (I) (we) last saw the deceased alive on <b>6/21/81</b> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE <b>Debra Bunker</b> MD					22c DATE SIGNED <b>6/22/81</b>			22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Deborah B Goldberg</b>		
22e ADDRESS <b>1106 Spring St, Silver Spring Maryland</b>										
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>6/25/81</b>		23c NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood P.G. Maryland</b>				
24 FUNERAL DIRECTOR NAME <b>F. Gasch's Sons F.H. P.A. Hyattsville, Md.</b>					25a DATE REC'D. BY REGISTRAR <b>JUN 24 1981</b>		25b REGISTRAR'S SIGNATURE			

BP

DHMH-16 50M/1/81  
(VRA 15, 4)





1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		26. DATE KNOWN OF DEATH		ESTIMATED		MONTH		DAY		YEAR		27. HOUR											
MARION FRANCES ELY								6-12-81		9:36A								9:36A											
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		27b. HOUR									
Female		White		01 01 13		68 YRS.		MONTHS		DAYS		6-12-81		19				9:36A		M									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH																	
Washington, D.C.				U.S.A.								Montgomery MD.																	
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY																	
Olney				Montgomery General Hospital				Household				Home																	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																													
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS													
Maryland				Montg.				Silver Spg.				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				14136 Whispering Pine Ct.													
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME																			
FIRST MIDDLE LAST										FIRST MIDDLE LAST																			
Clarence										Marion Pumphrey																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (yes, no, OR UNKNOWN)										16b. SOCIAL SECURITY NO.										17. INFORMANT									
no										578-42-3854										Barbara Walderon Forestville, MD									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART I DEATH WAS CAUSED BY:																													
IMMEDIATE CAUSE (a) <u>Pulmonary Embolus (Fat)</u>																		5 days											
8880 DUE TO, OR AS A CONSEQUENCE OF																													
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																													
(b) <u>Fracture both hips</u>																		8 days											
DUE TO, OR AS A CONSEQUENCE OF																													
(c)																													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY?													
6-7-81				Bilateral hip fractures & l. knee												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																					
				6:44 1981				Fall at home																					
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION				CITY OR TOWN				COUNTY				STATE									
				Home				Whispering Pine & Silver Spg				Montg				MD													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																													
ACTUAL SIGNATURE										TITLE (SPECIFY)										DATE SIGNED									
John S. Rogers										M.D. Dep.										June 12/81									
EXAMINER'S NAME (TYPE OR PRINT)										ADDRESS																			
John S. Rogers										1919 Seminary Road										Silver Spring, Maryland									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION																	
Burial				June 15, 1981				Cedar Hill Cemetery				Suitland Prince Georges MD																	
24. FUNERAL DIRECTOR										25a. DATE REC'D. BY REGISTRAR										25b. REGISTRAR'S SIGNATURE									
Lee Funeral Home, Inc.										JUN 17 1981																			
33 Old Alexander Ferry Rd., Clinton, MD																													

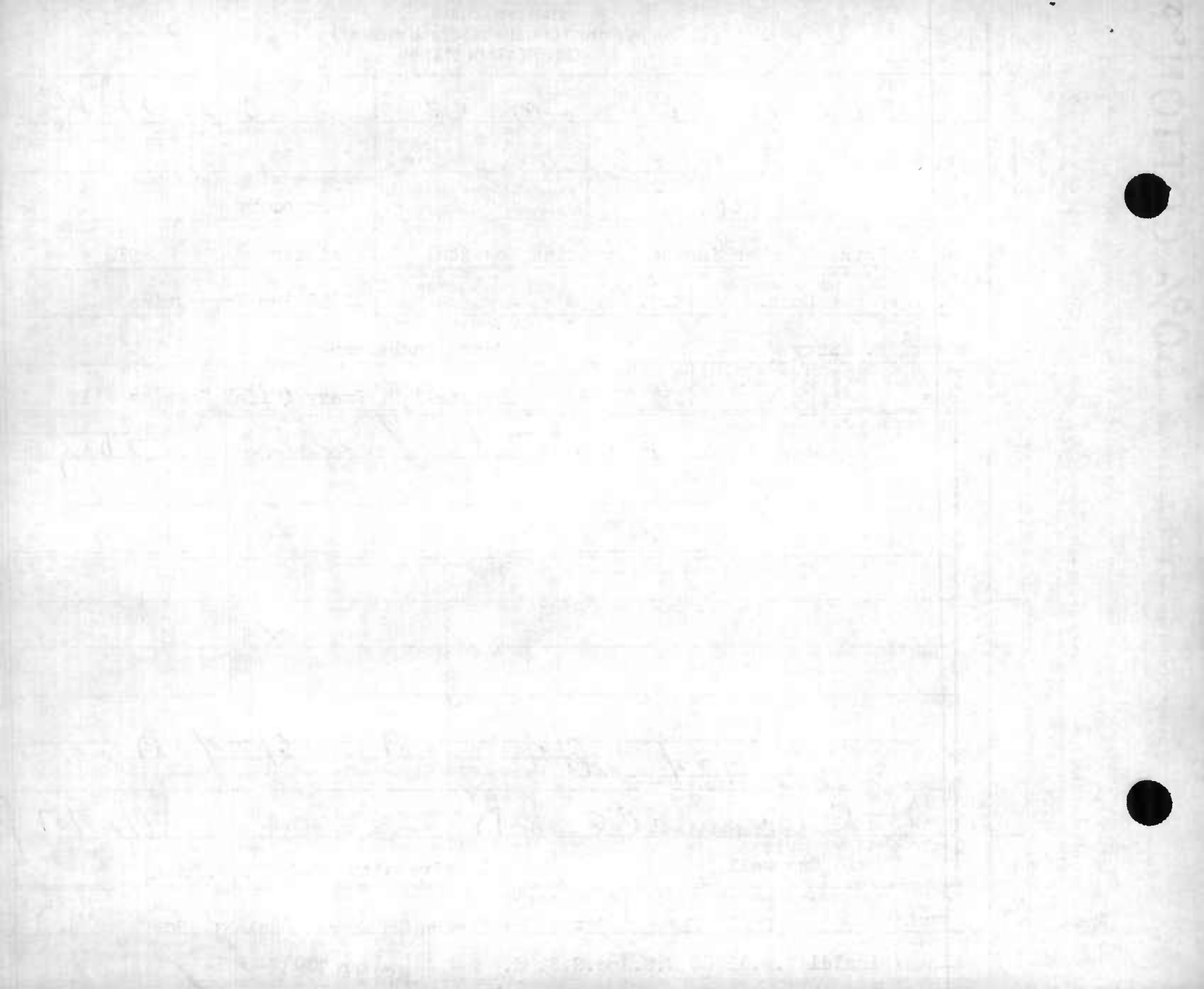


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
CERTIFICATE OF DEATH										
1- FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>EDWARD B EMERY</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>6-22-81</b>			2b. HOUR <b>8:10</b> AM		
3 SEX <b>MALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6-15-1902</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penn.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD				
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Painter</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>NIH</b>		
13a. STATE <b>Md.</b>					13b. COUNTY <b>Mont.</b>		13c. CITY OR TOWN <b>S.S.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edward B. Emery</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sarah Buchanan</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>None</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>579 07 6688</b>		17. INFORMANT ADDRESS <b>Christell D. Emery (Wife) Same as #13E</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 Days</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>6/4/81</b> 19 <b>81</b> to <b>6/22/81</b> 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>6/22/81</b> 19 <b>81</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.										
22b. SIGNATURE <b>David Cromwell</b>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>6/23/81</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>David Cromwell</b>					22e. ADDRESS <b>831 University Blvd. E. S.S.Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>6/25/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>George Washington Cemetery Adelphi</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Pc Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Hines/Rinaldi F.H.11800 N.H.Ave.S.S.Md.</b>					25a. DATE REC'D. BY REGISTRAR <b>JUN 30 1981</b>					
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>										



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

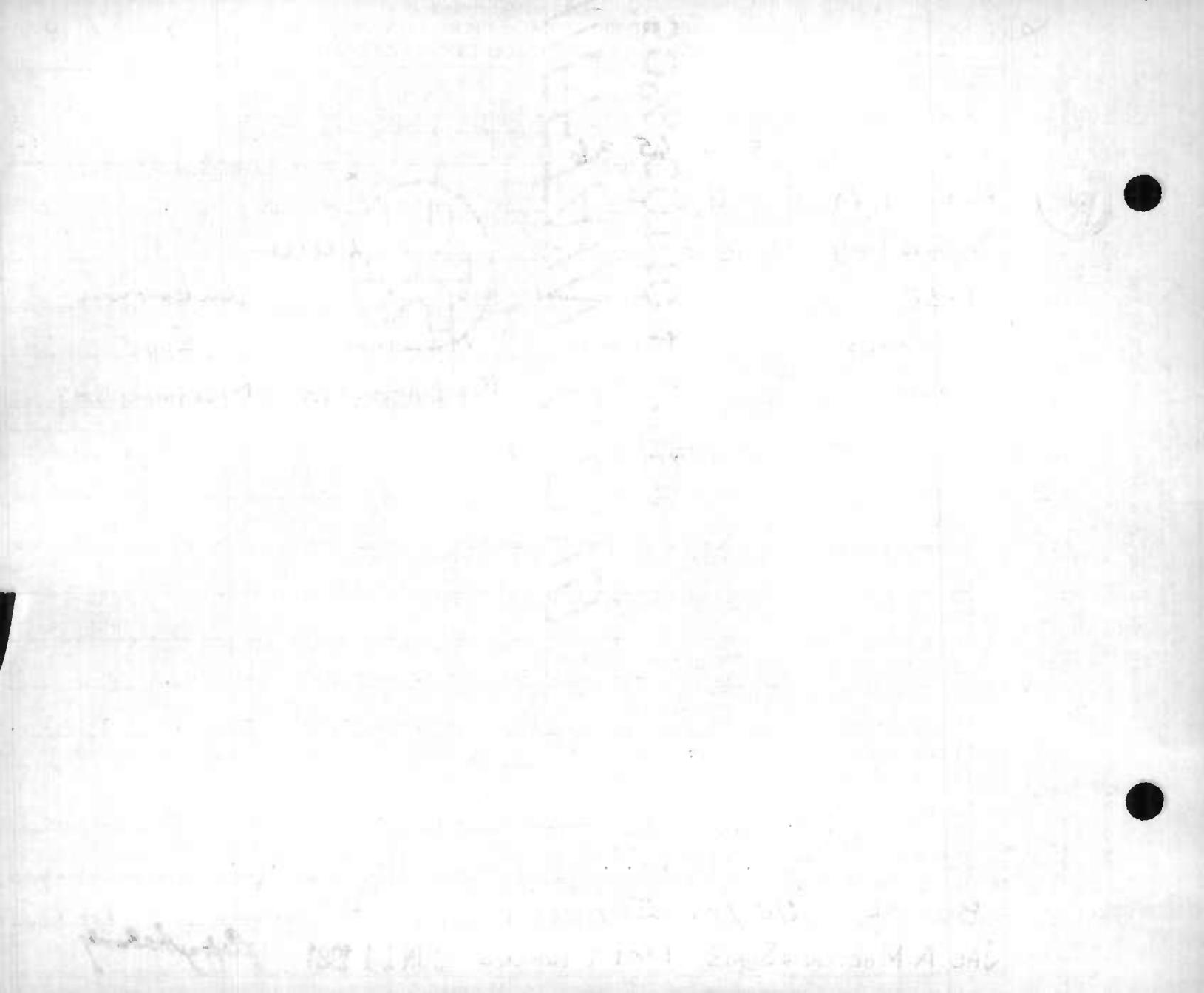
BP

DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST JAMES		MIDDLE EPPS		LAST		2a. DATE KNOWN OF ESTI- DEATH MATED		MONTH 6		DAY 9		YEAR 19 81		2b. HOUR M			
3. SEX male		4. RACE negro		5. DATE OF BIRTH MONTH 3		DAY 4		YEAR 45		6. AGE (IN YEARS LAST BIRTHDAY) 36 YRS.		IF UNDER 1 YR. MONTHS		IF UNDER 24 HRS. DAYS		HOURS		MIN.			
7a. BIRTHPLACE: (STATE OR FOREIGN COUNTRY) Richmond, VA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co.		MD		2c. DATE PRONOUNCED DEAD		MONTH 6		DAY 9		YEAR 19 81		2d. HOUR 8:25 M			
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Hospital		12a. USUAL OCCUPATION (TYPE OF WORK IF POSSIBLE WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY				13a. STATE D.C.		13b. COUNTY Washington		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Unknown			
14. FATHER'S NAME FIRST JAMES		MIDDLE		LAST MANN		15. MOTHER'S MAIDEN NAME FIRST MARION		MIDDLE Epps		LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. UNK.		17. INFORMANT Mrs. Marion Epps - Richmond, VA.		ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)																				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I																					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?																		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR XXXX MONTH DAY YEAR 6 P.M. 6-9- 19 81		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2) Subject drowned while swimming.																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.) water		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Isaac Walton Lake, Gaithersburg, Montgomery, Md.																	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																					
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER																		DATE SIGNED 6-10-81	
EXAMINER'S NAME (TYPE OR PRINT)		Ann M. Dixon, M.D.																		ADDRESS 111 Penn St.	
23a. BURIAL, CREMATION, REMOVAL (SEE IF)		23b. DATE 6/5/81		23c. NAME OF CEMETERY OR CREMATORY Evergreen		23d. LOCATION CITY OR TOWN COUNTY STATE Richmond VA.															
24. FUNERAL DIRECTOR NAME		JAS. A. MORTON & SONS		ADDRESS 1701 LAURENS		25a. DATE REC'D. BY REGISTRAR JUN 11 1981		25b. REGISTRAR'S SIGNATURE [Signature]													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 1 1 6 2 7 7	
1. FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR	
PAUL B FARMER					6/1/81					1:55 P M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
MALE		CAUCASIAN		JUNE 21, 1916		64 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
VIRGINIA		U.S.A.				MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda MD		Suburban Hospital				CARPENTER		SELF EMPLOYED			
13a. STATE					13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		
MARYLAND					MONTGOMERY		SILVER SPRING		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME						
NOAH FARMER					ROXIE MOORE						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
YES					WWII		PAULINE FARMER SAME AS 13 WIFE				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <i>Diabetes mellitus &amp; complications -</i>											
2502 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) <i>Hypercholesterolemia &amp; Retinopathy</i>											
DUE TO, OR AS A CONSEQUENCE OF											
(c) <i>Aspiration pneumonia &amp; lung abscess</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
<i>Cardio-respiratory failure</i>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
				HOUR A.M. MONTH DAY YEAR		X/4					
21d. INJURY OCCURRED				21e. PLACE OF INJURY		21f. LOCATION					
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				[AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]		CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>May 18</i> , 19 <i>81</i> , to <i>June 1</i> , 19 <i>1981</i> that (I) (we) last saw the deceased alive on <i>May 30</i> , 19 <i>81</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
<i>A. B. Antonio</i>				<i>MD</i>				<i>6/1/81</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
ADELAIDA B. ANTONIO				11141 GEORGIA AVE WHEATON MD 20852							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. COUNTY STATE			
BURIAL		6/4/81		PARKLAWN CEMETERY		ROCKVILLE		MONT MD.			
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
FRANCIS J. COLLINS						JUN 2 1981		<i>Francis J. Collins</i>			
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901											





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and retained by the hospital or attending physician.

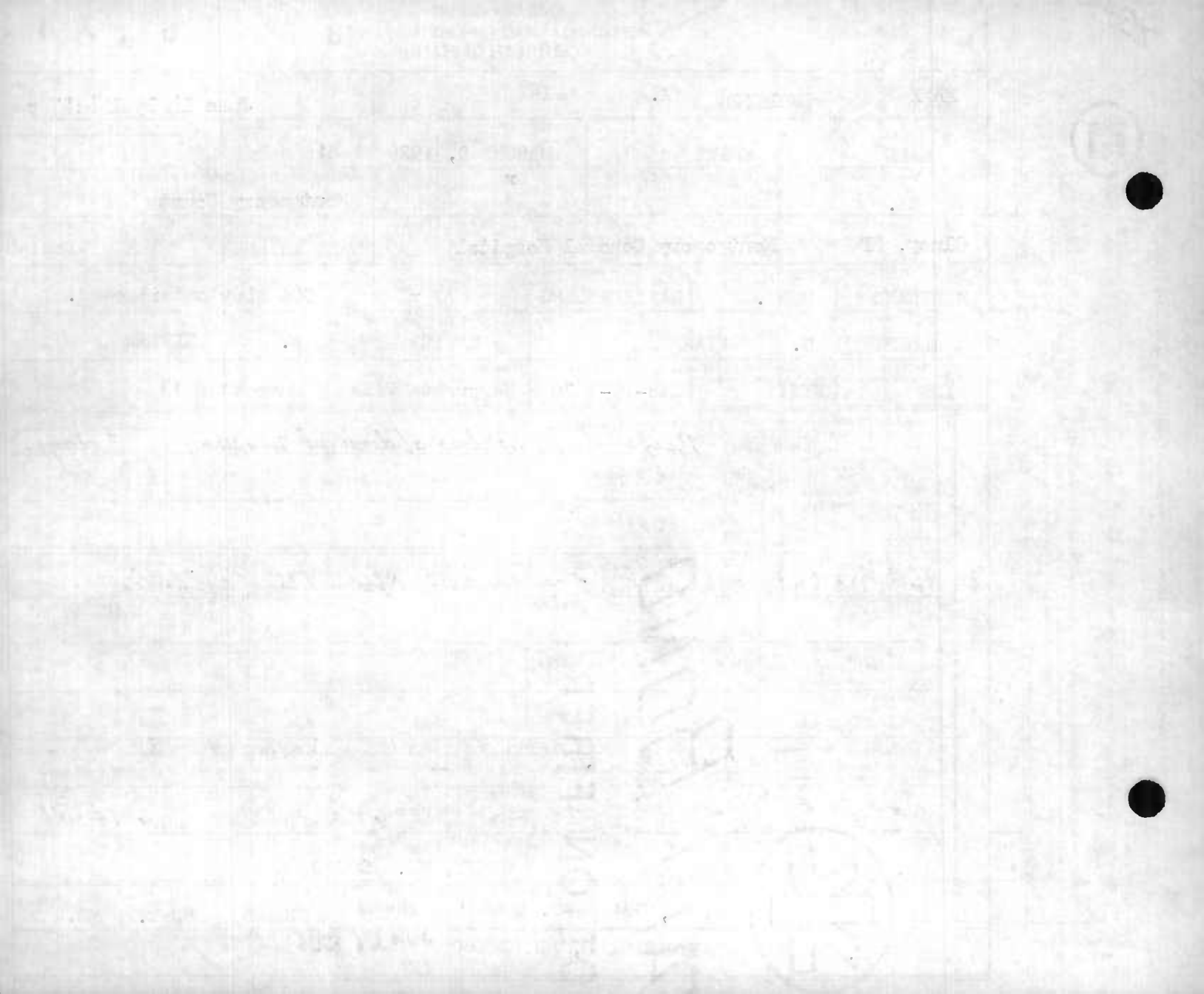
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in advance.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 1 1 6 2 7 8	
1- FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) <del>XXXX</del> RAYMOND A. FINK					2a. DATE OF DEATH MONTH DAY YEAR June 14 1981			2b. HOUR 4:47 p.m.			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MARCH 9, 1920		6. AGE (IN YEARS LAST BIRTHDAY) 61		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.					
10. CITY OR TOWN OF DEATH Olney, MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TREE TRIMMER		12b. KIND OF BUSINESS OR INDUSTRY TREE TRIMMING			
13a. STATE MARYLAND				13b. COUNTY MONT.		13c. CITY OR TOWN GAITHERSBURG		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 506 Laytonsville Rd.	
14. FATHER'S NAME FIRST MIDDLE LAST ALBERT G. FINK					15. MOTHER'S MAIDEN NAME MIDDLE LAST KATIE A. KEPLER						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT Margretta Fink		ADDRESS Same as # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Perforation, hollow abdominal viscous</u> 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>ASCVD, CHF, Hypersensitivity pneumonitis, Rheumatoid arthritis</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>Jan. 4</u> , 19 <u>81</u> , to <u>Jan. 14</u> , 19 <u>81</u> , that (I) <u>(we)</u> lost saw the deceased alive on <u>June 13</u> , 19 <u>81</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> (did) (do not) view the body after death.											
22b. SIGNATURE <u>Donald E. Dillon M.D., by</u> <u>Frederick Moomau, M.D.</u> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										22c. DATE SIGNED 6-14-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. FREDERICK MOOMAU						22e. ADDRESS OLNEY, MD. 20832					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE JUNE 16, 1981		23c. NAME OF CEMETERY OR CREMATORY ST. LUKES' LUTHERAN		23d. LOCATION CITY OR TOWN COUNTY STATE REDLAND MONT. MD.			
24. FUNERAL DIRECTOR FRANCIS H. BARBER LAYTONSVILLE, MD. 20760											

JUN 17 1981

REGISTRAR'S SIGNATURE



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>SYLVESTER FOWLER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>June 13, 1981</b>			2b. HOUR <b>3:10am</b>			
3 SEX <b>MALE</b>		4 RACE <b>BLACK</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>Sept. 21, 1901</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10 CITY OR TOWN OF DEATH <b>Olney</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery General Hospital</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Janitorial service</b>		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE <b>Md.</b>			13b CITY OR TOWN <b>Howard</b>		13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d STREET ADDRESS <b>13212 Clarksville Pike</b>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>Jake Fowler</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lillie Mae Kelly</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b SOCIAL SECURITY NO. <b>820-01-4789</b>		17 INFORMANT ADDRESS <b>Mary Fowler (wife) same as #13</b>				
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pneumonia</b> 4860 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b>	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>ASCVD CHF and permanent pneumonia, Parkinson's disease, Dialysis</b>									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (the hospital) attended the deceased from <b>June 6, 1981</b> to <b>June 13, 1981</b> , that (I) (we) last saw the deceased alive on <b>Jan 12, 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b SIGNATURE <b>Frederick Moomau, M.D.</b> DEGREE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>6-13-81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Frederick Moomau, M.D.</b>						22e. ADDRESS <b>18111 Prince Phillip Dr., Olney, Md.</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>6-16-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hopkins Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Highland, Howard, Md.</b>		
24. FUNERAL DIRECTOR NAME <b>George R. Snowden</b>						24b. ADDRESS <b>246 N. Washington Street Rockville, Md. 20850</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 17 1981</b>	
						25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

WIFE

BLACK

Sent. 21. 1901

VA

U.S.A.

Id.

Unionist service

13215 Chapinville Pike

Highland

Howard

Id.

13111 "an Kelly

John Fowler

820-01-4789 Mary Fowler (wife) care at 113

Id.

Fredrick Noonan, N.O.

4-18-01

Hopkins Cemetery

Burial

18111 Prince William Dr., Olney, Md.

Highland, Howard, Md.

748 N. Washington Street

George W. Stoddard

Rockville, Md.

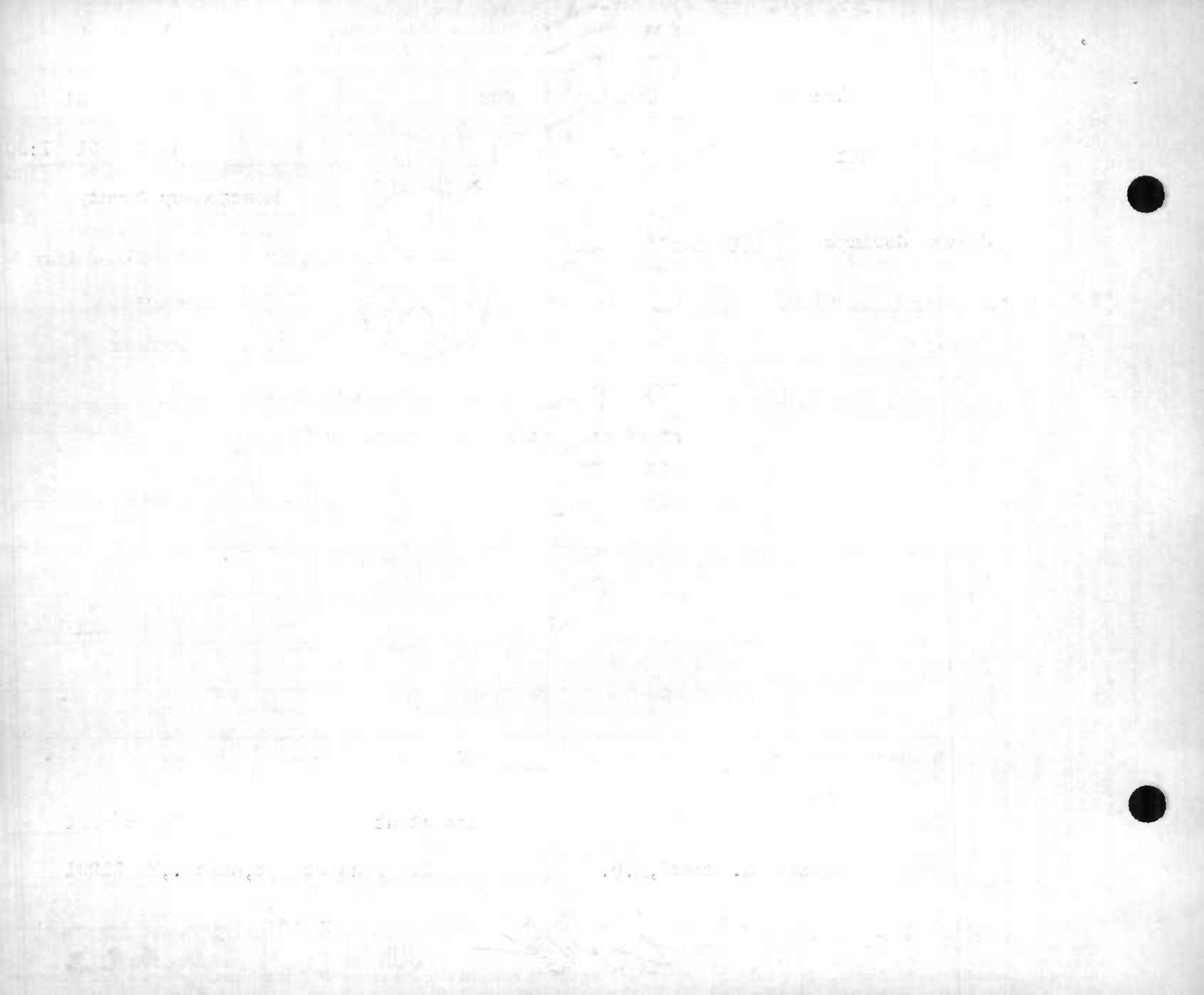
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST Archie		MIDDLE William		LAST Fox		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 6 5 19 81				2b. HOUR AM			
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 12 27 41		6. AGE (IN YEARS) LAST BIRTHDAY 39 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 6 5 19 81				7d. HOUR 7:30 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U S A				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Silver Springs				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1415 Harding Lane				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plumber				12b. KIND OF BUSINESS OR INDUSTRY Plumbing			
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spr.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1414 Harding Lane					
14. FATHER'S NAME FIRST MIDDLE LAST Archie W Fox						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice W. Locker									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				(IF YES, GIVE WAR OR DATES) -----		16b. SOCIAL SECURITY NO. 218 38 5945		17. INFORMANT ADDRESS Kim Fox (same as # 13)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE H. S. Guard				TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER				DATE SIGNED 6/5/81			
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.				ADDRESS 111 Penn Street, Balto., MD 21201											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 6-8-81		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Mont. Md.					
24. FUNERAL DIRECTOR Walter E. Pumphrey				ADDRESS 8434 Ga. Ave. Silver Spring, Md.				25a. DATE REC'D. BY REGISTRAR JUN 11 1981				25b. REGISTRAR'S SIGNATURE L. J. H. H. H.			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201





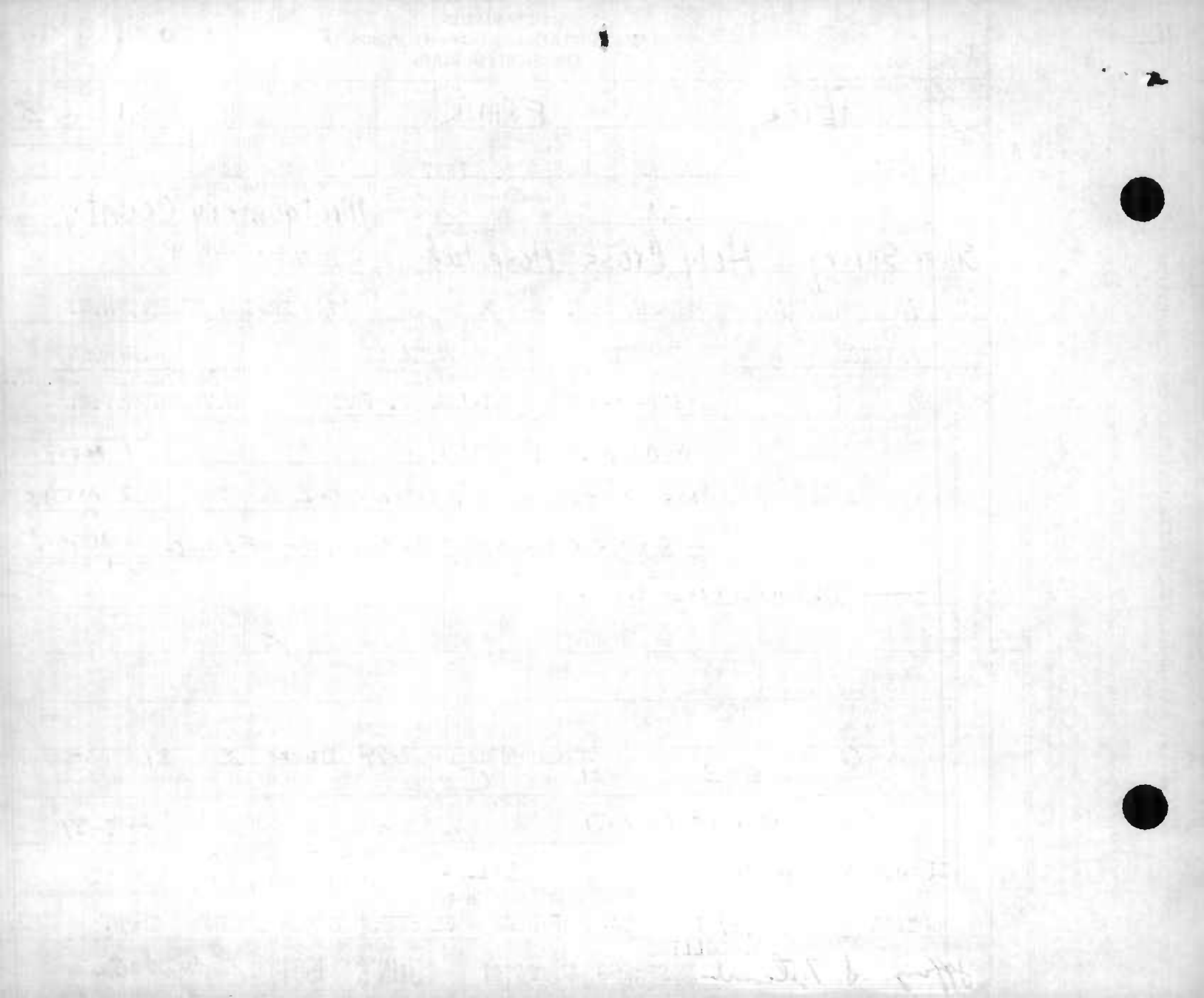
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR						8116281					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>PETER FRANK</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>6 3 81</b>		2b. HOUR <b>2:15 PM</b>			
3. SEX <b>MALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>FEB 22, 1897</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84 YRS</b>		IF UNDER 1 YEAR MONTHS DAYS <b>84 YRS</b>		IF UNDER 24 HRS HOURS MIN. <b>2:15 PM</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>GREECE</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD</b>					
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RESTAURANTEUR</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>N/A</b>		13b. CITY OR TOWN <b>WASH, D.C.</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>1745 IRVING STREET, N.W.</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>VASILIOS FRANGIS</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>VASILIKI UNKNOWN</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>578-48-1670</b>		17. INFORMANT <b>SON WILLIAM P. FRANK</b>		ADDRESS <b>5936 GARRISON ST., N.W. WASHINGTON, D.C.</b>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1629 MALNUTRITION</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>METASTATIC CARCINOMA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>EPIDERMOID CARCINOMA OF LUNG</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 MTH</b> <b>2 MTHS</b> <b>6 MTH?</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>DECUBITUS ULCERS</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (this hospital) attended the deceased from <b>JANUARY 19 1974</b> to <b>JUNE 3 1981</b> , that (1) (we) lost saw the deceased alive on <b>6-3-81</b> , and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>John B. Nason, MD</b>				DEGREE				22c. DATE SIGNED <b>6-3-81</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN B. NASON</b>				22e. ADDRESS <b>800 GERTHING DR. SILVER SPRING, MD 20910</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>6/5/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>SILVER SPRING MONT MD.</b>					
24. FUNERAL DIRECTOR <b>FRANCIS J. COLLINS</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 5 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Robert McBratney</b>					
25c. ADDRESS <b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>											



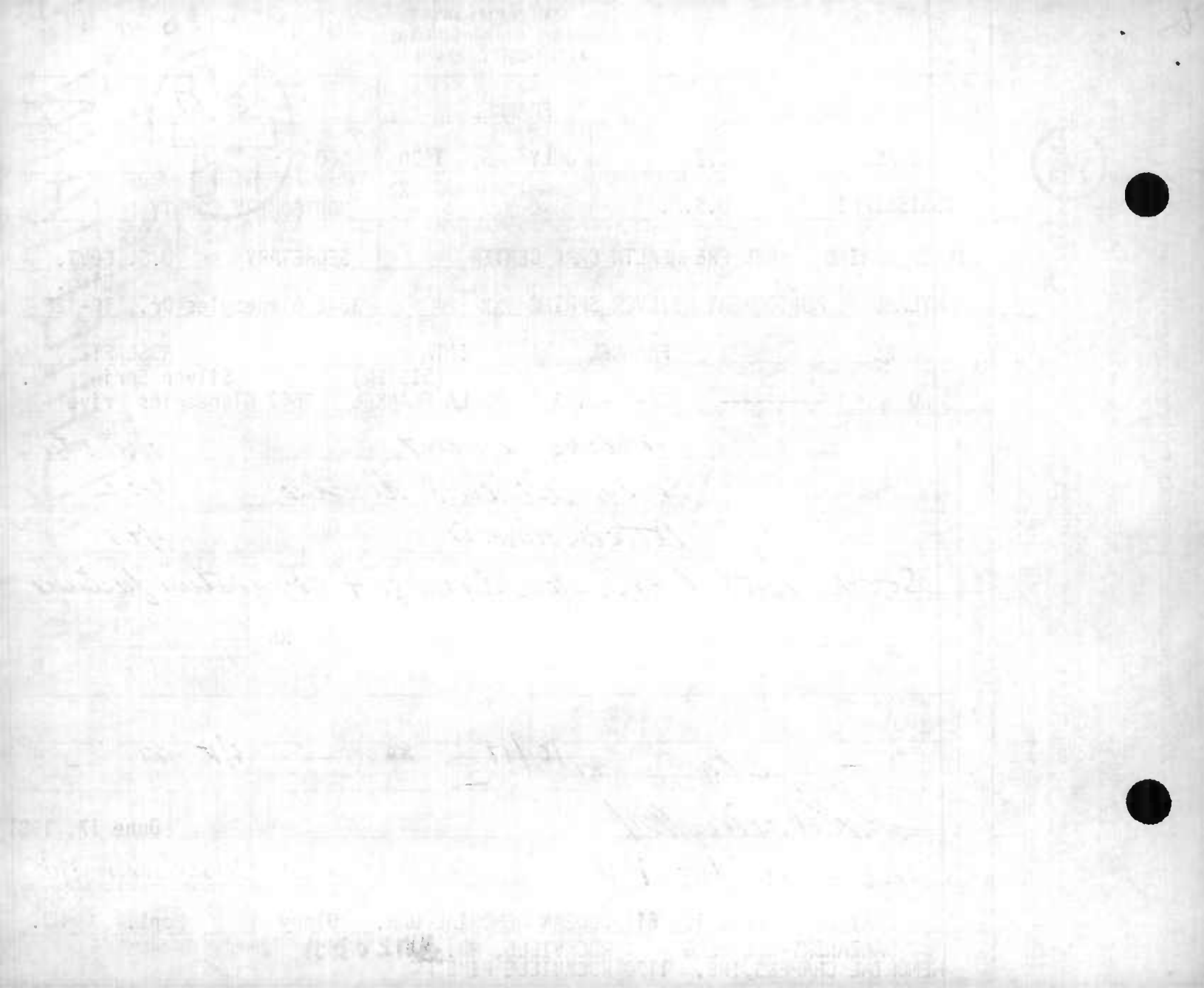
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MARIAN FRANKEL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6 17 81</b>		2b. HOUR <b>2:15 A</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JULY 5, 1920</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>60</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MISSISSIPPI</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> XX WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY COUNTY MD.</b>
10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BEL PRE HEALTH CARE CENTER</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SECRETARY</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. GOVT.</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>SILVER SPRING</b>		13d. INSIDE CITY LIMITS? <b>YES XX NO <input type="checkbox"/></b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>MOSES FRANKEL</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>INTA ROSENFELD</b>		16. ADDRESS <b>Silver Spring, MD. 3642 Gleneagles Drive</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>434-24-0183</b>		17. INFORMANT (SISTER) <b>PAULA FRANKEL</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>4360</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Severe ischemic disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <b>Arteriosclerosis</b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <b>Stroke with brain stem damage + congestive failure</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> XX		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>10/17</b> , 19 <b>80</b> , to <b>4/17</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>4/17</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>Richard P. Delaney M.D.</b>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>June 17, 1981</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Richard P. Delaney M.D.</b>		22e. ADDRESS <b>4323 Harvard St. Silver Spring Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>June 19, 81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>JUDEAN MEMORIAL GAR.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Olney Mont. MD.</b>
24. FUNERAL DIRECTOR NAME <b>DANZANSKY-GOLDBERG</b> ADDRESS <b>ROCKVILLE, MD.</b> <b>MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE</b>						



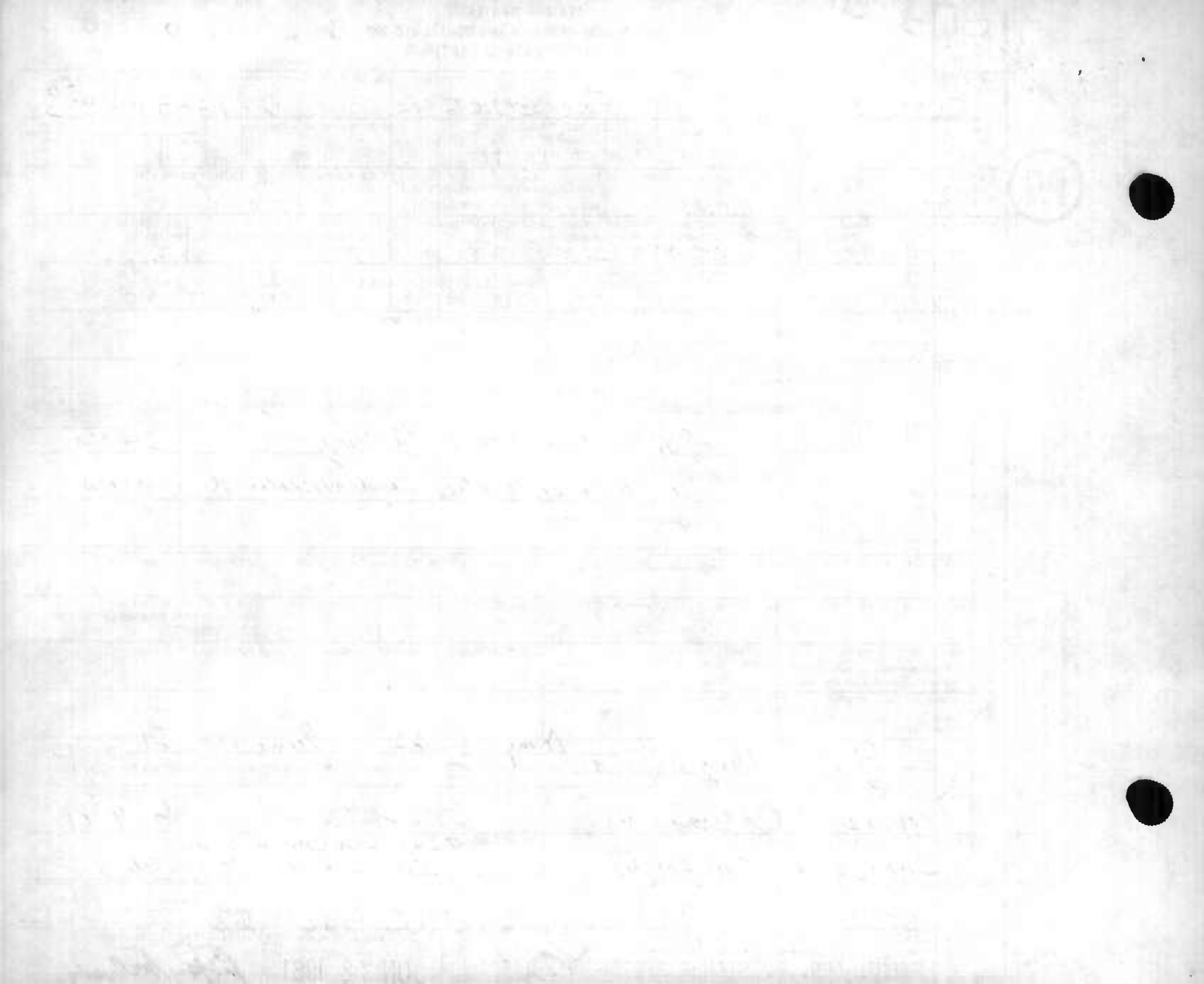
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 15 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ELMER L. FREEBURGER</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>6-18-81</b>			
3. SEX <b>MALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>FEB 14, 1894</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>87</b>	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.	
10. CITY OR TOWN OF DEATH <b>CHEVY CHASE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>CHEVY CHASE NURSING HOME</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>PRESSMAN</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>G.P.O.</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. CITY OR TOWN <b>MARYLAND MONTGOMERY SILVER SPRING</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>8811 COLESVILLE ROAD</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>ALBERT FREEBURGER</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>FLORENCE JENKINS</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO <b>220-44-7601</b>		17. INFORMANT ADDRESS <b>MARGARET E. FREEBURGER SAME AS 13 WIFE</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4292 Congestive heart failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerotic cardiovascular d</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>years</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b>							18
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <b>June 11</b> 19 <b>81</b> and that in my <b>own</b> opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>James R. Coleman</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>6/19/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JAMES R. COLEMAN</b>				22e. ADDRESS <b>9241 COLUMBIA BLVD SILVER SPRING, Md. 20910</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>6/22/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BRENTWOOD PRI GEO MD.</b>	
24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 22 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Robert H. B...</b>	
26. ADDRESS <b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>							



## CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Frank R. Friberg					6	1	81		4:05AM
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male	Caucasian	March 25 1934		47	MONTHS		DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Massachusetts	U.S.A.			Montgomery MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Olney	Montgomery General Hospital			Research Scientist		CIA			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS				
Maryland		Montgomery	Rockville	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	1977 Lancashire Drive				
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
Frank W. Friberg		Ellen Fagerstrom							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
Yes		Navy Reserve		Joan M. Friberg (same as 13e)					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Hepatic failure</u>								1 wk	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hepatic metastasis</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Adenocarcinoma of colon</u>								1979	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c): <u>Lung metastasis.</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>81</u> , to <u>1 June</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>31 May</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
<u>Donald E. Dillon MD</u>						1 June 81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
Dr. Donald Dillon				18111 Prince Philip Dr., Olney, Md. 20832					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		June 3, 1981		Gate of Heaven Cem.		Silver Spring Montg. Md.			
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Robert A. Pumphrey Funeral Homes P/A				JUN 8 1981		<u>Robert A. Pumphrey</u>			
300 W. Montgomery Ave., Rockville, Md. 20850									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					8 1 1 6 2 8 5				
1- FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ANTHONY S GALOTTO</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>6-12-81</b> 9:19 P. M.				
3 SEX <b>Male</b>		4 RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10-15-01</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>ITALY</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10 CITY OR TOWN OF DEATH <b>TAKOMA PK</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WASHINGTON ADVENTIST HOSP.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Photo Engraver</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Printing</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>					13b. CITY OR TOWN <b>Washington, D.C.</b>		13c. STREET ADDRESS <b>4201 BUTTER WORTH PL. N.W.</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>ROCCO GALOTTO</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CARMELA Alpieri</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>065-10-1359</b>		17 INFORMANT <b>Dr. John Galotto</b>		ADDRESS <b>9204 Fall River Lane Potomac, Md. 20854</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Squamous cell Lung CA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>-</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>8 months</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) -			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (a) (this hospital) attended the deceased from <b>6/8</b> 19 <b>81</b> , to <b>6/12</b> 19 <b>81</b> , that (b) (we) lost saw the deceased alive on <b>6/12</b> 19 <b>81</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (b) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Peter B. Sherer</b>					DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>6/13/81</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PETER B. SHERER MD</b>					22e. ADDRESS <b>1109 Spring St. Silver Spring md 20910</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>June 17, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Patterson Passiac N.J.</b>		
24 FUNERAL DIRECTOR NAME <b>Francis J. Collins</b>					25a. DATE REC'D. BY REGISTRAR <b>JUN 15 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Pietro Calabro</b>		
500 University Blvd. W. Silver Spring, Md.									

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*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some words like "Washington, D.C." and "Mr. John G. ..."*

100 University Road, W. Silver Spring, Md.  
Francis J. Collins  
June 17, 1961  
Robert Kennedy  
Washington, D.C.  
Enclosed

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Julia</b>		FIRST <b>Garb</b>		LAST		2a. DATE OF DEATH MONTH DAY YEAR <b>June 6, 1981</b>		2b. HOUR <b>11:00 A.M.</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>MAY 20, 1895</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY CO.</b>			
10. CITY OR TOWN OF DEATH <b>ROCKVILLE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NATIONAL LUTHERAN HOME</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CLERICAL WORKER-UNKNOWN</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>MARYLAND</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3501-ST. PAUL ST.,</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>SIGMUND GARB</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CLARA (GARB)</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT ADDRESS <b>REV. DR. RICHARD REICHARD-9701-VEIRS DR.,</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>5850</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YEARS MONTHS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>5-31, 1979</b> to <b>6-6, 1981</b> , that (I) (we) last saw the deceased alive on <b>6-6, 1981</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Dr. Thomas Dooley</b>								22c. DATE SIGNED <b>6-6-1981</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. THOMAS DOOLEY</b>				22e. ADDRESS <b>9701-VEIRS DR., ROCKVILLE, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>JUNE 10, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>SUITLAND, MARYLAND</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>HYSONG FUNERAL HOME 1300 N St. N.W. Wash. D.C.</b>									

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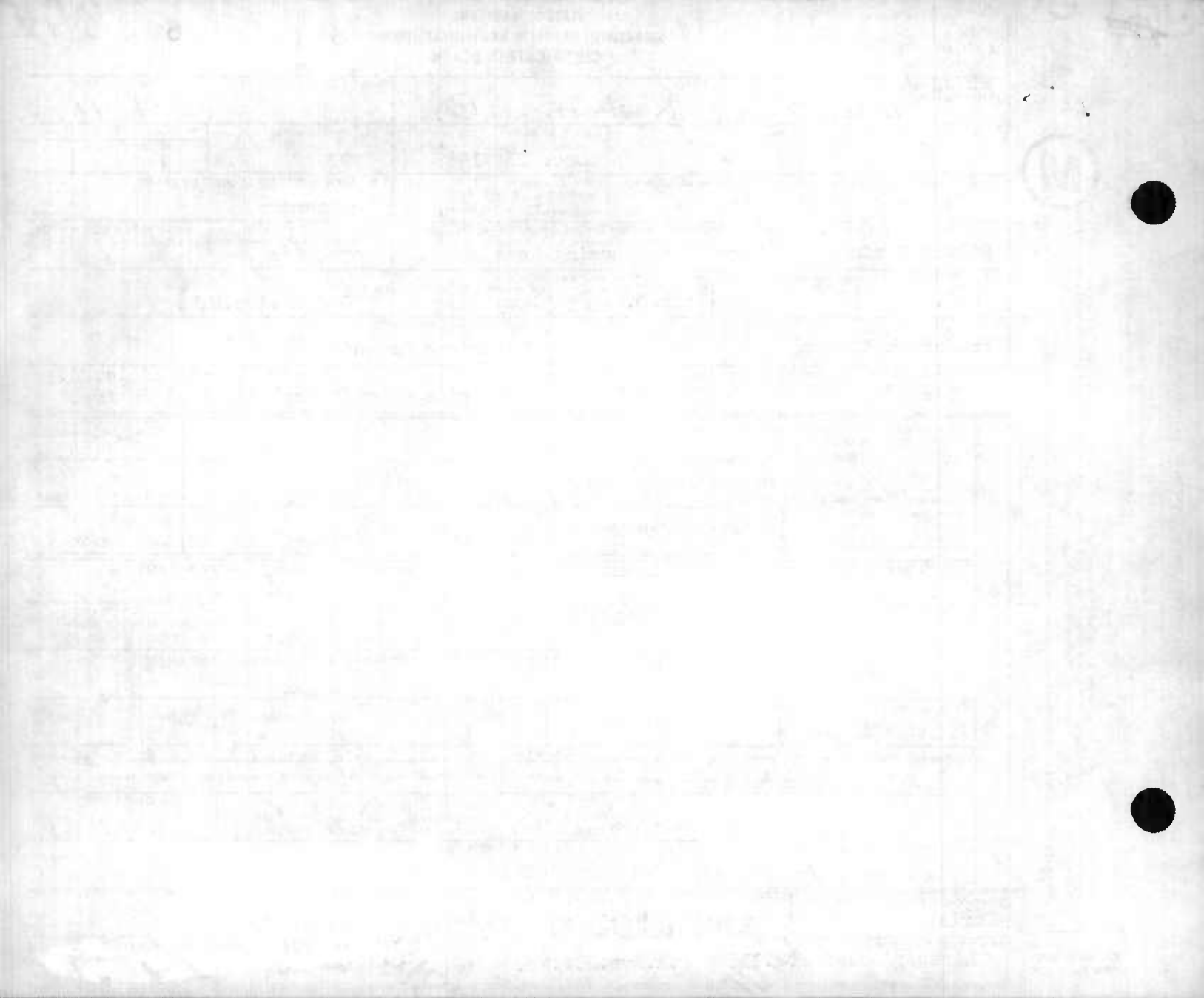
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 1 1 6 2 8 1			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
GARDNER, Katherine B.				6-17-81				7A. M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS	
F		W		Dec. 23 1888		92 YRS		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		USA				Montgomery MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION				12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring		Chevy Chase Nursing Home				Housewife					
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
D.C.						Wash. D.C.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3900 Conn. Ave. N.W.	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
Frederick Binger				Christiana Deewaid							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
None				579 62 5642		Katherine Chew (Niece)		Temple Hills, Md. 4319 Sheldon Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY											
IMMEDIATE CAUSE (a) <u>Septicemia</u>								5 days			
2639 DUE TO, OR AS A CONSEQUENCE OF <u>Pneumonitis</u>								5 days			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost											
DUE TO, OR AS A CONSEQUENCE OF <u>Gen. inanition</u>								2 mos.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a)											
<u>Left hemiplegia due to C.V.A. (thrombosis)</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		21d. LOCATION			
				HOUR A.M. MONTH DAY YEAR		ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2		CITY OR TOWN COUNTY STATE			
				P.M. 19							
21e. INJURY OCCURRED				21f. PLACE OF INJURY		21g. LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				[AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]		STREET		CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 16</u> , 19 <u>65</u> , to <u>June 17</u> , 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>June 16</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE								DEGREE		22c. DATE SIGNED	
Thomas F. McMahon MD								ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/>		6-17-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)								22e. ADDRESS			
Thomas F. McMahon MD								2737 Devonshire Pl. N.W. Wash. D.C.			
23a. BURIAL, CREMATION, REMOVAL				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial				6/20/81		Rock Creek Cemetery		Wash. D.C. COUNTY STATE			
24. FUNERAL DIRECTOR								25a. b.			
Hines/Rinaldi F.H. 11800 N.H. Ave. S.S. Md.								JUN 22 1981		Rising/Robinson	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 6 2 8 8			
1- FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) <u>Lillian Agnes Gerard</u>				2a DATE OF DEATH MONTH DAY YEAR <u>6/13/81</u>		2b HOUR <u>9:50 AM</u>	
3 SEX <u>F</u>		4 RACE <u>Cau</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>8 23 92</u>		6 AGE (IN YEARS LAST BIRTHDAY) <u>88</u> YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>ENGLAND</u>		7b CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery County</u> MD	
10 CITY OR TOWN OF DEATH <u>Bethesda</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Bethesda Health Center</u>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Nurse</u>		12b KIND OF BUSINESS OR INDUSTRY <u>Nursing</u>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13b STREET ADDRESS <u>5721 Grosvenor Lane</u>	
13a STATE <u>Maryland</u>		13b COUNTY <u>Mont. Co.</u>		13c CITY OR TOWN <u>Bethesda</u>			
14 FATHER'S NAME FIRST MIDDLE LAST <u>William - Gerard</u>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Ann - Basil</u>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b SOCIAL SECURITY NO. <u>578-48-2003</u>		17 INFORMANT ADDRESS <u>Ernest Dermatatis 806 15th St. NW Washington, DC</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4280 Congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <u>Organic brain syndrome</u>							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>19</u> P.M.		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (1) (this hospital) attended the deceased from <u>3-18</u> 19 <u>81</u> , to <u>6-13</u> 19 <u>81</u> , that (1) (we) last saw the deceased alive on <u>5-30</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.							
22b SIGNATURE <u>James H. Brodsky</u> MD				22c DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d DATE SIGNED <u>6-13-81</u>	
22e PHYSICIAN'S NAME (TYPE OR PRINT) <u>James H. Brodsky</u> MD				22f ADDRESS <u>4701 Willard Ave Chevy Chase</u>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		23b DATE <u>June/16/81</u>		23c NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d LOCATION CITY OR TOWN COUNTY STATE <u>Suitland, P.G. Co., Maryland</u>	
24 FUNERAL DIRECTOR NAME ADDRESS <u>Chambers Funeral Home Riverdale, Maryland</u>				25a DATE REC'D. BY REGISTRAR <u>JUN 19 1981</u>		25b REGISTRAR'S SIGNATURE <u>Jeffrey A. Brodsky</u>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 6 2 8 9			
1- FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
FIRST MIDDLE LAST <u>Rose A. Giesen</u>				MONTH DAY YEAR <u>June 20, 1981</u>			
3. SEX <u>Female</u>		4. RACE <u>Caucasian</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>January 1, 1888</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>93</u> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Canada</u>		7b. CITIZEN OF WHAT COUNTRY? <u>United States</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery</u> MD.	
10. CITY OR TOWN OF DEATH <u>Bethesda</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>SUBURBAN</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housewife</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
13a. STATE <u>Maryland</u>				13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Bethesda</u>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>William Pfistner</u>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Anna Tritchler</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>368-32-0193</u>		17. INFORMANT ADDRESS <u>Dorothea V. Mc Gavin Same as 13</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA</u> <u>7070</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEPTICEMIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>LARGE DERMATITIS ULCENS</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>6 months</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>ORGANIC BRAIN SYNDROME</u>							
19a. DATE OF OPERATION <u>—</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2) <u>—</u>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u>—</u>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <u>—</u>			
22a. I certify that (I) (this hospital) attended the deceased from <u>MARCH 10, 1981</u> , to <u>JUNE 20, 1981</u> , that (I) (we) lost saw the deceased alive on <u>JUNE 19, 1981</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Roland Imperial MD</u>				DEGREE <u>MD</u>		22c. DATE SIGNED <u>June 20/81</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ROLAND IMPERIAL</u>				22e. ADDRESS <u>4977 BATTERY LANE Bethesda</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>June 23, 1981</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Silver Spring, Maryland</u>	
24. FUNERAL DIRECTOR NAME <u>Robert A. Pumphrey</u>				ADDRESS <u>Homes, P.A. Bethesda, Maryland</u>		25a. DATE RECD. BY REGISTRAR <u>JUN 25 1981</u>	

Robert A. Murphy (Marty)

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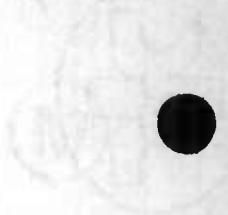
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 6 2 9 0			
FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
Richard V Gillespie				6 16 81 12 30 AM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
MALE		CAUCASIAN		MAY 17, 1903		78 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
MARYLAND		U.S.A.				Montgomery MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring		Holy Cross Hospital		MAINTENANCE PLUMBER		U.S. GOVT.	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
MARYLAND		MONTGOMERY		SILVER SPRING		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS			
JAMES F. GILLESPIE		JULIA A. ZINK		25 EAST WAYNE AVENUE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
NO		578-09-5848		MARY E. GILLESPIE		SAME AS 13 WIFE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) 4149 CARDIAC ARREST				IMMEDIATE			
DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DISEASE				15 YRS.			
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: CARCINOMA OF COLON (CECUM) - PERFORATION							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
6/13/81		CARCINOMA OF COLON		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 6/15 19 81, to 6/16 19 81, that (I) (we) last saw the deceased alive on 6/15 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.							
22b. SIGNATURE OF PHYSICIAN				22c. DEGREE		22d. DATE SIGNED	
DAVID GOLDENBERG				MD		6/16/81	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL				6/18/81		GATE OF HEAVEN	
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
FRANCIS J. COLLINS				20901 JUN 22 1981		Rising/Robinson	
500 UNIV. BLVD., W., SILVER SPRING, MD.							

EX-111-1



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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## CERTIFICATE OF DEATH

8 1 1 6 2 9 1

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WILLIE MAE Gilliam			2a. DATE OF DEATH MONTH DAY YEAR 6-9-81			2b. HOUR 4:15 PM			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 5-18-19		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 114 HARMONY HALL RD.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.			13b. COUNTY Mont.		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Herbert Knight			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Hickey			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			
16b. SOCIAL SECURITY NO. 328-14-9940			17. INFORMANT Shirley Bishop same as 13c						
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Adenocarcinoma of breast</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years 8 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (the hospital) attended the deceased from 19 78 to 6/9/81, that (I) (we) lost saw the deceased alive on 6/8/81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
22b. SIGNATURE G. Lennard Gold, M.D.					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/9/81		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. Lennard Gold					22e. ADDRESS 8630 Fenton Street Silver Spring, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/13/81		23c. NAME OF CEMETERY OR CREMATORY Robins Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Pattonsville, Virginia			
24. FUNERAL DIRECTOR NAME ADDRESS Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Maryland					25a. DATE REC'D. BY REGISTRAR JUN 11 1981		25b. REGISTRAR'S SIGNATURE [Signature]		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.



Shirley Bishop was an life

6630 Tanton Street Silver Spring, Md.

Pattonville, Virginia

Robins Cemetery

0/12/81

Harold

Tyson Wheeler Funeral Home, Inc.

1371 Rockville Pike Rockville, Maryland

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 16292	
1. DECEASED NAME (TYPE OR PRINT) <b>ROBERT C. GLAUBMAN</b>						2a. DATE KNOWN OF DEATH MONTH DAY YEAR <b>6-14-81</b>		2b. HOUR <b>1:30</b>		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>6-14-81</b>	
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 5 58</b>		6. AGE (IN YEARS) LAST BIRTHDAY YRS. <b>23</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>6-14-81</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b>		
10. CITY OR TOWN OF DEATH <b>Bethesda</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>STUDENT</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>LAW SCHOOL</b>	
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>ROCKVILLE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>9320 WESCOTT PLACE 20850</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>JULES - - - GLAUBMAN</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>HARRIET - - - FISHBEIN</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES-NO, OR UNKNOWN) <b>NO</b>			(IF YES, GIVE WAR OR DATES) <b>- - -</b>			16b. SOCIAL SECURITY NO. <b>217-76-1776</b>		17. INFORMANT ADDRESS <b>L.WM.SKOLNICK, 9320 WESCOTT PL. ROCKVILLE, MD</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>Multiple injuries</b> IMMEDIATE CAUSE (a) <b>8/120</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <b>8/120</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>8/120</b> DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>6/? 81</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>driver in auto/auto collision</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>hwy.</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Falls Road Montgomery Co., Maryland</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Margarita A. Korell</b>				TITLE (SPECIFY) <b>M.D. Assistant</b>				DATE SIGNED <b>6-14-81</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>				ADDRESS <b>111 Penn Street</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>JUNE 16, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>KING DAVID MEM. GARDEN</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>FALLS CHURCH, FAIRFAX, VIRGINIA</b>			
24. FUNERAL DIRECTOR <b>DANZANSKY-GOLDBERG MEM. CHAPELS, ROCKVILLE, MD.</b>						25a. DATE REC'D. BY REGISTRAR <b>JUN 17 1981</b>					

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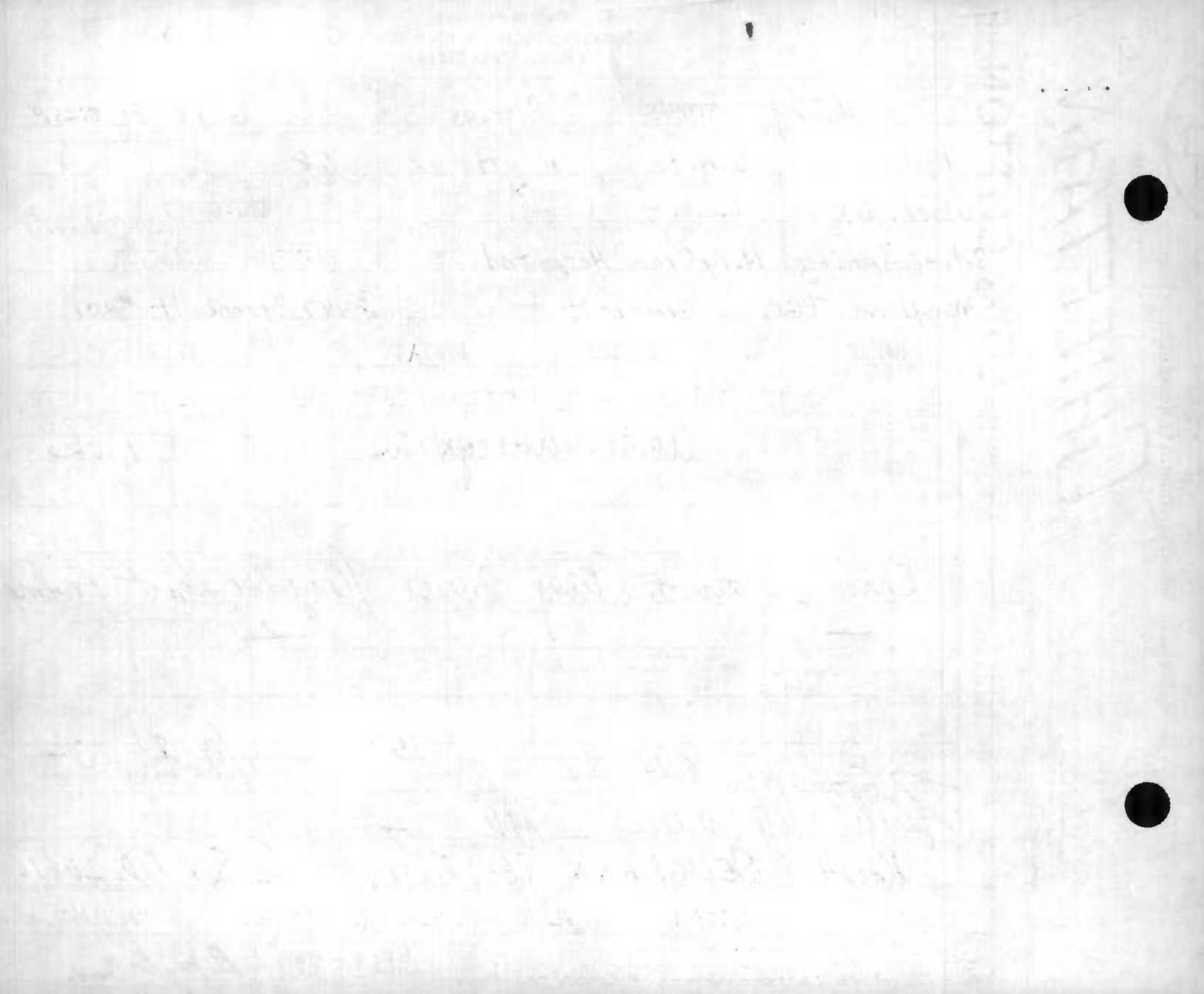
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Harry THOMAS Glorius</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>6 14 81</b> 2b. HOUR <b>3:25 PM</b>				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 17 13</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wash. D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY MD.</b>			
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>PAINTING CONTRACTOR</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. CITY OR TOWN <b>Greenbelt</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>8447 Greenbelt #201</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>HARRY A. GLORIUS</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LYDIA PAYNE</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II</b>		17. INFORMANT <b>GERTRUDE C. GLORIUS</b>		ADDRESS <b>SAME AS 13 WIFE</b>			
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cholecystitis</b> 5750 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF (d) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION OF DEATH (PART 1): <b>Chronic Obstructive Lung Disease / Longtime Heart Failure</b>									
19a. DATE OF OPERATION <b>—</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF OTHER, HISTORY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>6/14 81</b> to <b>6/14 81</b> , that (I) (we) lost the deceased on <b>6/14 81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, state and did not view the body after death.)									
22b. SIGNATURE <b>Ralph E. Deligmann</b>					DEGREE <b>MD</b>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RALPH E. DELIGMANN</b>					22e. ADDRESS <b>8630 FENTON ST. SIL. SPR MD. 20910</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>6/17/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MARYLAND NATL MEM. PK.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>LAUREL MARYLAND</b>			
24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b>					25a. DATE REC'D. BY REGISTRAR <b>JUN 15 1981</b>				
ADDRESS <b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>					25b. REGISTRAR'S SIGNATURE <b>L. H. H. H.</b>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 6 2 9 4			
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
Catherine M. Graham				June 18 81			
3. SEX				4. RACE			
Female				white			
5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)			
Feb. 4, 1897				84			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?			
New York				USA			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION			
Rockville				Collingwood Nursing Home			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Secretary							
13a. STATE				13b. COUNTY			
Maryland				Mont.			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
George				Mary			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.			
no				578 54 9935			
17. INFORMANT				ADDRESS			
Robert F. Graham (son)				# 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a)				4340			
DUE TO, OR AS A CONSEQUENCE OF				Cerebral Thrombosis			
(b)				Hypertension with no evidence			
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
Cerebral Thrombosis							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
YES <input type="checkbox"/> NO <input type="checkbox"/>				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY			
				HOUR A.M. MONTH DAY YEAR			
				P.M. 19			
21d. INJURY OCCURRED				21e. PLACE OF INJURY			
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			
21f. LOCATION				21g. LOCATION			
STREET				CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from June 17, 19 81, to June 18, 19 81, that (we) lost the deceased alive on June 17, 19 81, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (Initials) (did) (did not) view the body after death.							
22b. SIGNATURE				22c. ADDRESS			
Paul Noone, M.D.				50 W. Edmonston Rd. Rockville, Md.			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
Paul Noone, M.D.				50 W. Edmonston Rd. Rockville, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE			
Burial				June 20, 1981			
23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION			
Gate of Heaven				Silver Spring, Md.			
24. FUNERAL DIRECTOR				24. DATE RECD. BY REGISTRAR			
W.W. Taltavull				JUN 22 1981			
4748 Wisc. Ave. N.W. Wash. D.C. 20016				7b. REGISTRAR'S SIGNATURE			





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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FOR 1- STATE REGISTRAR												DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)						FIRST JOHN						MIDDLE GRAHAM						LAST GRAHAM						2a. DATE KNOWN OF DEATH ESTI-MATED		<input checked="" type="checkbox"/> MONTH 6 13 19 81		2b. HOUR 152 M	
3. SEX M		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 7 10 25		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD 6 13 19 81		2d. HOUR 152 M		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.													
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) 70 WALLACE, N.C.						7b. CITIZEN OF WHAT COUNTRY? U.S.A						8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) OIL CO.						12b. KIND OF BUSINESS OR INDUSTRY									
10. CITY OR TOWN OF DEATH 71 TAKOMA PARK						11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSP						13a. STREET ADDRESS 3300 6th St SE						13b. CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS 3300 6th St SE									
13a. STATE DC						13b. COUNTY -						13c. CITY OR TOWN WASHINGTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		15. MOTHER'S MAIDEN NAME IRENE													
14. FATHER'S NAME FIRST MIDDLE LAST Elliott GRATHAM						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IRENE						16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OF DATES) YES ARMY & NAVY						16b. SOCIAL SECURITY NO. 227-20-1645						17. INFORMANT MAMIE GRATHAM		ADDRESS 3300 6th St. S.E. #102			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERIOSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). DIABETES MELLITUS												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE INDEF																	
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY HOUR AM. MONTH DAY YEAR 1230 P.M. 6 13 19 81						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) COLLAPSED IN CAR BACK SEAT																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) STREET						21f. LOCATION STREET CITY OR TOWN COUNTY STATE TAKOMA PARK GRO STATION MONT. MD.																	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												TITLE (SPECIFY) M.D. JEFF		DATE SIGNED 6/13/81															
ACTUAL SIGNATURE Francis C Mayle Jr						MEDICAL EXAMINER 8200 Wisconsin Ave Bethesda MD						EXAMINER'S NAME (TYPE OR PRINT) Francis C Mayle Jr																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial						23b. DATE 6/20/81						23c. NAME OF CEMETERY OR CREMATORY WASH. NAT. CEM.						23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Md. Baltimore MD											
24. FUNERAL DIRECTOR NAME R.G. MASON FUNERAL HOME.						ADDRESS 1661 6600 Hope Rd SE.						25a. DATE REC'D. BY REGISTRAR JUN 18 1981						25b. REGISTRAR'S SIGNATURE [Signature]											

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Michael Emanuel Gramatikos</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6/27/81</b>			2b. HOUR <b>11:35 PM</b>			
3. SEX <b>MALE</b>		4. RACE <b>C. CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>MARCH 20, 1917</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PENNSYLVANIA</b>		9. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY MD.</b>			
12. CITY OR TOWN OF DEATH <b>TAKOMA PARK</b>		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WASHINGTON ADVENTIST HOSPITAL</b>				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>BARTENDER</b>		15. KIND OF BUSINESS OR INDUSTRY <b>MIXOLOGIST</b>	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE <b>MARYLAND</b>		16b. COUNTY <b>PRINCE GEO.</b>		16c. CITY OR TOWN <b>TAKOMA PARK</b>		16d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		16e. STREET ADDRESS <b>815 LARCH AVENUE</b>	
17. FATHER'S NAME FIRST MIDDLE LAST <b>EMANUEL GRAMATIKOS</b>		18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>VASILIA SPANOS</b>		19. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		20. SOCIAL SECURITY NO. <b>232-03-4983</b>		21. INFORMANT <b>MANDY GRAMATIKOS</b>	
22. ADDRESS <b>SAME AS 13</b>		23. WIFE <b>WIFE</b>		24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>occlusion bilateral cerebral arteries</b> 4349 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral vascular accident</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hypertension, diabetic mellitus</b>		25. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>6-13-81</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
26. DATE OF OPERATION <b>6-27</b>		27. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Hypertension, diabetic mellitus</b>				28. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		29. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
30. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		31. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		32. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		33. CITY OR TOWN <b>SILVER SPRING</b>		34. COUNTY <b>MONT</b>	
35. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		36. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		37. LOCATION STREET <b>FALLS CHURCH</b>		38. CITY OR TOWN <b>FALLS CHURCH</b>		39. COUNTY <b>VIRGINIA</b>	
40. I certify that (1) this hospital attended the deceased from <b>6-18</b> , 19 <b>81</b> , to <b>6-27</b> , 19 <b>81</b> , the (1) (we) last saw the deceased alive on <b>6-27</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.									
41. SIGNATURE <b>John Kotak Jr MD</b>		42. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				43. DATE SIGNED <b>6-28-81</b>			
44. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN KOTAK</b>		45. ADDRESS <b>SILVER SPRING MONT MD.</b>				46. DATE REC'D. BY REGISTRAR <b>JUN 30 1981</b>			
47. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		48. DATE <b>6/30/81</b>		49. NAME OF CEMETERY OR CREMATORY <b>NATIONAL MEMORIAL PARK</b>		50. LOCATION CITY OR TOWN <b>FALLS CHURCH</b>		51. COUNTY <b>VIRGINIA</b>	
52. FUNERAL DIRECTOR'S NAME <b>FRANCIS J. COLLINS</b>		53. ADDRESS <b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>				54. DATE REC'D. BY REGISTRAR <b>JUN 30 1981</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



FOR  
STATE  
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

16297

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR			
John		A.		Grantham				X		06		11		81		3:17 AM			
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR			
M	W	05 10 11		70 YRS.						06		11		81		M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH													
WEST VIRGINIA		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery MD.													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
Silver Spring		Holy Cross Hosp.		INTERNATIONAL SALES REP		ITT													
13a. STATE		13b. CITY OR TOWN		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
Maryland		Montgomery		Silver Spring		YES <input type="checkbox"/> NO <input type="checkbox"/>		3925 Weller Rd.											
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																	
FIRST		MIDDLE		LAST		FIRST		MIDDLE		LAST									
JOHN		A.		GRANTHAM		VIRGINIA		M.		LEONARD									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
NO		577-10-0725		BLANCHE N. GRANTHAM		SAME AS 13		WIFE											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis.</u>																			
4291																			
DUE TO, OR AS A CONSEQUENCE OF																			
(b)																			
DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																			
None																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?															
None				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
		P.M. 19																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED															
John S. Rogers		M.D. Reg		MEDICAL EXAMINER		June 11/1981													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS																	
JOHN S. ROGERS		1919 SEMINARY ROAD, SILVER SPRING, MD.																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE									
BURIAL		6/13/81		PARKLAWN CEMETERY		ROCKVILLE		MONT		MD.									
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE															
FRANCIS J. COLLINS		JUN 12 1981		John S. Rogers															
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901																			





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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

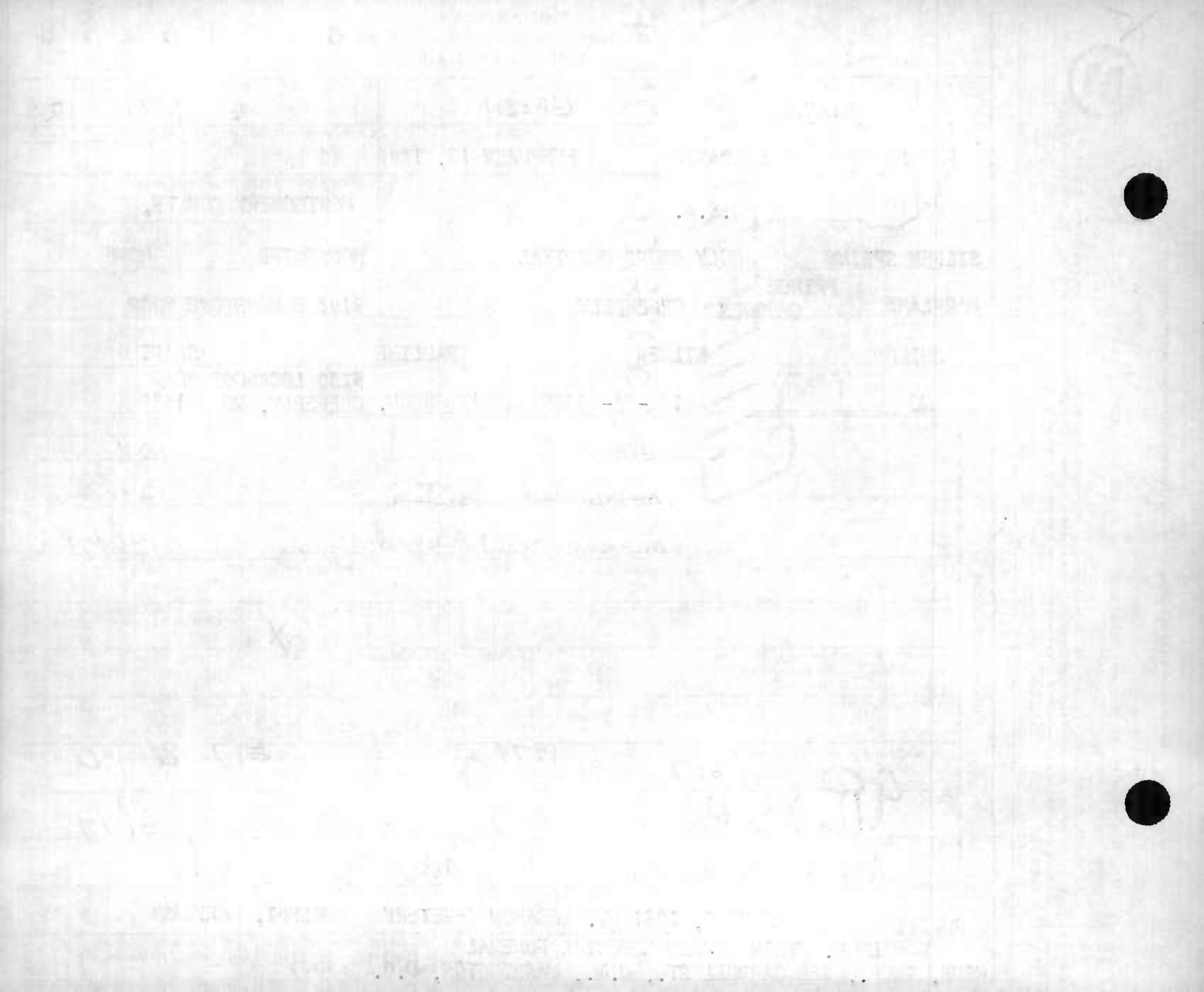
IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified of case.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 1 1 6 2 9 8	
1 - FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>BERTHA GREEN</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>6 7 81</b>		2b. HOUR <b>12:00 PM</b>				
3. SEX <b>FEMALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>FEBRUARY 13, 1898</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b>		IF UNDER 1 YEAR MONTHS DAYS <b>YRS.</b>		IF UNDER 24 HRS. HOURS MIN. <b>YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>POLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY COUNTY, MD.</b>					
10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOLY CROSS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>			
13a. STATE <b>MARYLAND</b>					13b. CITY OR TOWN <b>GREENBELT</b>		13c. STREET ADDRESS <b>9108 EDMONSTONE ROAD</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>SHIMON</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>PAULINE SHAPIRO</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>					16b. SOCIAL SECURITY NO. <b>100-26-4838D</b>		17. INFORMANT <b>5730 LOCKWOOD ROAD</b> <b>MURRAY GREEN, CHEVERLY, MD</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>shock</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>massive right pleural effusion</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 hours</b> <b>24 hours</b> <b>10 days</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)											
19a. DATE OF OPERATION <b>6/7/81</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>shock</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>1979</b> , 19____, to <b>6/7/81</b> , that (I) (we) lost saw the deceased alive on <b>6/7/81</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) did not view the body after death.											
22b. SIGNATURE <b>Mark S. Rosen</b>					DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>6/7/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Mark S. Rosen</b>					22e. ADDRESS <b>Silver Spring, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>JUNE 9, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT. LEBANON CEMETERY</b>			23d. LOCATION <b>ADELPHI, MARYLAND</b>			
24. FUNERAL DIRECTOR <b>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME, INC., 232 CARROLL ST., N.W., WASHINGTON, D.C.</b>					25a. DATE REC'D. BY REGISTRAR <b>JUN 10 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Jeffrey M. Cready</b>				







TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 16299	
1. DECEASED NAME (TYPE OR PRINT) <b>ERMA C. charlotte GRIDLEY</b>						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>June 14, 1981</b>		2b. HOUR <b>12:30</b>		2c. DATE PRONOUNCED DEAD <b>June 14, 1981</b>	
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 18, 1890</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD <b>June 14, 1981</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Montanna</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b>	
10. CITY OR TOWN OF DEATH <b>Olney</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Houswife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>MD</b>				13b. COUNTY <b>Mont</b>		13c. CITY OR TOWN <b>Sil. Spr</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>3406 Chiswick Ct</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Lincoln Greenwood</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret C. Brown</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>578 38 2039</b>		17. INFORMANT <b>12721 Feldon Street Doris Bryan Silver Spring, Md. 20906</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial bio</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <b>None</b>											
19a. DATE OF OPERATION <b>None</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>John S. Rogers</b>						TITLE (SPECIFY) <b>M.D. Dep.</b>			MEDICAL EXAMINER		
EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers</b>						ADDRESS <b>1919 Seminary Rd. Sil. Spr. Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>				23b. DATE <b>6-14-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan Crematory Alexandria</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Virginia</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Md. 20852</b>						25a. DATE REC'D. BY REGISTRAR <b>JUN 17 1981</b>			25b. REGISTRAR'S SIGNATURE		

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30005 . 54 , 21116 21117 21118 21119 21120 21121 21122 21123 21124 21125 21126 21127 21128 21129 21130 21131 21132 21133 21134 21135 21136 21137 21138 21139 21140 21141 21142 21143 21144 21145 21146 21147 21148 21149 21150 21151 21152 21153 21154 21155 21156 21157 21158 21159 21160 21161 21162 21163 21164 21165 21166 21167 21168 21169 21170 21171 21172 21173 21174 21175 21176 21177 21178 21179 21180 21181 21182 21183 21184 21185 21186 21187 21188 21189 21190 21191 21192 21193 21194 21195 21196 21197 21198 21199 21200 21201 21202 21203 21204 21205 21206 21207 21208 21209 21210 21211 21212 21213 21214 21215 21216 21217 21218 21219 21220 21221 21222 21223 21224 21225 21226 21227 21228 21229 21230 21231 21232 21233 21234 21235 21236 21237 21238 21239 21240 21241 21242 21243 21244 21245 21246 21247 21248 21249 21250 21251 21252 21253 21254 21255 21256 21257 21258 21259 21260 21261 21262 21263 21264 21265 21266 21267 21268 21269 21270 21271 21272 21273 21274 21275 21276 21277 21278 21279 21280 21281 21282 21283 21284 21285 21286 21287 21288 21289 21290 21291 21292 21293 21294 21295 21296 21297 21298 21299 21300 21301 21302 21303 21304 21305 21306 21307 21308 21309 21310 21311 21312 21313 21314 21315 21316 21317 21318 21319 21320 21321 21322 21323 21324 21325 21326 21327 21328 21329 21330 21331 21332 21333 21334 21335 21336 21337 21338 21339 21340 21341 21342 21343 21344 21345 21346 21347 21348 21349 21350 21351 21352 21353 21354 21355 21356 21357 21358 21359 21360 21361 21362 21363 21364 21365 21366 21367 21368 21369 21370 21371 21372 21373 21374 21375 21376 21377 21378 21379 21380 21381 21382 21383 21384 21385 21386 21387 21388 21389 21390 21391 21392 21393 21394 21395 21396 21397 21398 21399 21400 21401 21402 21403 21404 21405 21406 21407 21408 21409 21410 21411 21412 21413 21414 21415 21416 21417 21418 21419 21420 21421 21422 21423 21424 21425 21426 21427 21428 21429 21430 21431 21432 21433 21434 21435 21436 21437 21438 21439 21440 21441 21442 21443 21444 21445 21446 21447 21448 21449 21450 21451 21452 21453 21454 21455 21456 21457 21458 21459 21460 21461 21462 21463 21464 21465 21466 21467 21468 21469 21470 21471 21472 21473 21474 21475 21476 21477 21478 21479 21480 21481 21482 21483 21484 21485 21486 21487 21488 21489 21490 21491 21492 21493 21494 21495 21496 21497 21498 21499 21500 21501 21502 21503 21504 21505 21506 21507 21508 21509 21510 21511 21512 21513 21514 21515 21516 21517 21518 21519 21520 21521 21522 21523 21524 21525 21526 21527 21528 21529 21530 21531 21532 21533 21534 21535 21536 21537 21538 21539 21540 21541 21542 21543 21544 21545 21546 21547 21548 21549 21550 21551 21552 21553 21554 21555 21556 21557 21558 21559 21560 21561 21562 21563 21564 21565 21566 21567 21568 21569 21570 21571 21572 21573 21574 21575 21576 21577 21578 21579 21580 21581 21582 21583 21584 21585 21586 21587 21588 21589 21590 21591 21592 21593 21594 21595 21596 21597 21598 21599 21600 21601 21602 21603 21604 21605 21606 21607 21608 21609 21610 21611 21612 21613 21614 21615 21616 21617 21618 21619 21620 21621 21622 21623 21624 21625 21626 21627 21628 21629 21630 21631 21632 21633 21634 21635 21636 21637 21638 21639 21640 21641 21642 21643 21644 21645 21646 21647 21648 21649 21650 21651 21652 21653 21654 21655 21656 21657 21658 21659 21660 21661 21662 21663 21664 21665 21666 21667 21668 21669 21670 21671 21672 21673 21674 21675 21676 21677 21678 21679 21680 21681 21682 21683 21684 21685 21686 21687 21688 21689 21690 21691 21692 21693 21694 21695 21696 21697 21698 21699 21700 21701 21702 21703 21704 21705 21706 21707 21708 21709 21710 21711 21712 21713 21714 21715 21716 21717 21718 21719 21720 21721 21722 21723 21724 21725 21726 21727 21728 21729 21730 21731 21732 21733 21734 21735 21736 21737 21738 21739 21740 21741 21742 21743 21744 21745 21746 21747 21748 21749 21750 21751 21752 21753 21754 21755 21756 21757 21758 21759 21760 21761 21762 21763 21764 21765 21766 21767 21768 21769 21770 21771 21772 21773 21774 21775 21776 21777 21778 21779 21780 21781 21782 21783 21784 21785 21786 21787 21788 21789 21790 21791 21792 21793 21794 21795 217

— 412 —

2-14-71  
Kinetel Home, Inc.

431 Rockville Pike Rockville, Md. 20855

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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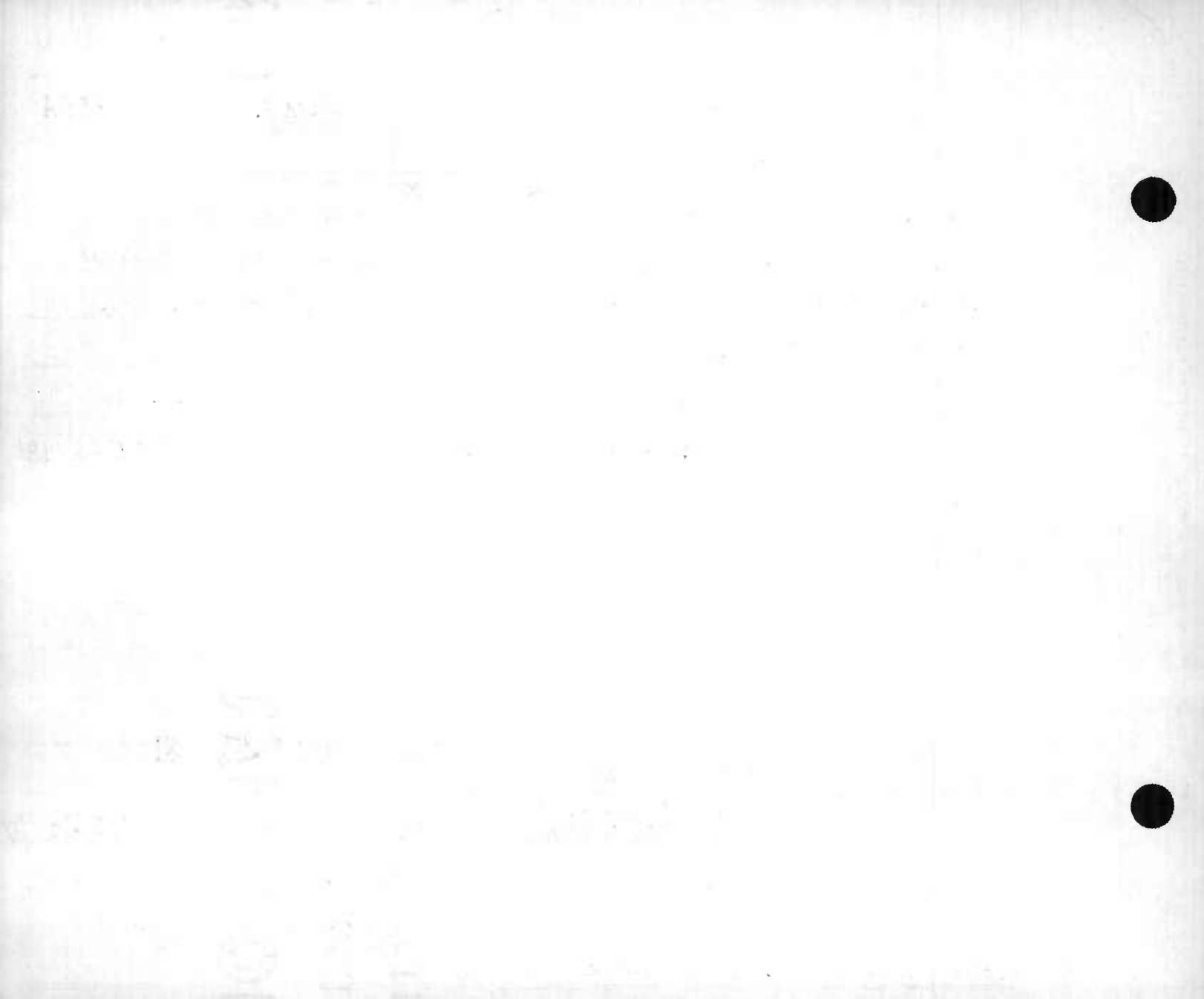
FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 1 1 6 3 0 0

1. DECEASED NAME (TYPE OR PRINT) Michael Bruce Grubb			2a. DATE OF DEATH MONTH DAY YEAR JUNE 23 1981			2b. HOUR 855A.M.				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR January 26, 1945		6. AGE (IN YEARS LAST BIRTHDAY) 36 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.				
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5401 Westbard Avenue, Apt. 1508				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Stock Broker		12b. KIND OF BUSINESS OR INDUSTRY Financial		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5401 Westbard Ave., Apt. 1508	
14. FATHER'S NAME FIRST MIDDLE LAST William R. Grubb				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marion E. Dennis						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None 048-34-8960		17. INFORMANT ADDRESS W. Dennis Grubb - Bro. 2900 Conn. Ave., N.W. Wash. D.C.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Pancreas (1-81) → 1579 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH JUNE 23, 1981		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22. I certify that (I) (this hospital) attended the deceased from June 11, 1981, to JUNE 23, 1981, that (I) (we) last saw the deceased alive on JUNE 11, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Richard W. Holt M.D. DEGREE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED JUNE 23, 1981		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard W. Holt, M.D.						22e. ADDRESS 3800 Reservoir Rd., N.W., Washington, D.C.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE June 25, 1981		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Montgomery Md.			
24. FUNERAL DIRECTOR NAME W.W. Chambers Co. 8653 GA AVE. S.S. MD. 20910						25a. DATE FILED BY REGISTRAR JUN 26 1981		25b. REGISTRAR'S SIGNATURE		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) Henry Ova Hansen						2a. DATE OF DEATH MONTH DAY YEAR 6 27 81		2b. HOUR 645 P.M.	
3. SEX male		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 7 30 1893		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW JERSEY		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH TACOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSP:				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BARBER		12b. KIND OF BUSINESS OR INDUSTRY SELF-EMP.	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MD.		13b. COUNTY MONT.		13c. CITY OR TOWN TACOMA PK.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 706 KENNEBEC AVE.	
14. FATHER'S NAME FIRST MIDDLE LAST VIGO HANSEN					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST THORA KRONE				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. WW1 152-09-9505		17. INFORMANT ADDRESS ANNA HANSEN SAME AS 13 E.				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1533 IMMEDIATE CAUSE (a) Metastatic Cancer from Colon DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 wks.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Partial Bowel obstruction									
19a. DATE OF OPERATION Nov 1980		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cancer sigmoid				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from June 27 1980, to June 27 1981, that (I) (we) lost saw the deceased alive on June 27 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Robert A. Smith						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/28/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert A. Smith						22e. ADDRESS 831 University Blvd. E. Silver Spring Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JULY 1, 1981		23c. NAME OF CEMETERY OR CREMATORY GEORGE WASH. MEM.		23d. LOCATION CITY OR TOWN COUNTY STATE PARAMUS BERGEN N.J.			
24. FUNERAL DIRECTOR IVES FUNERAL HOME 2847 WILSON BLVD. ARL						25a. DECEASED BY REGISTERED PHYSICIAN 25b. REGISTERED PHYSICIAN'S SIGNATURE			

U.S. DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 6 3 0 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>FRANCES K. HARKINS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>June 18, '81</b>		2b. HOUR P <b>3:10 P</b>
3. SEX <b>FEMALE</b>	4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>March 3, 1913</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Mass.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.		
10. CITY OR TOWN OF DEATH <b>Kensington</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Kensington Gardens San.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>		13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Silver Spring</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>3449 Chiswick Ct.</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Keough</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Teresa Howe</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>034-03 5737</b>	17. INFORMANT <b>Silver Spring, Md. 20906</b> <b>Robert W. Harkins-husband 3449 Chiswick Ct.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b> DUE TO OR AS A CONSEQUENCE OF (b) <b>CHRONIC OBSTRUCTIVE Pulmonary Dis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Alcoholism</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4960</b> <b>3 DAYS</b> <b>YEARS</b> <b>years</b>					APPROPRIATE AGENCY FOR RECORDING DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, PARK, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) the hospital attended the deceased from <b>June 18, '81</b> to <b>4/18/81</b> , that (1) (a) lost saw the deceased alive on <b>4/18/81</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z) (aa) (ab) (ac) (ad) (ae) (af) (ag) (ah) (ai) (aj) (ak) (al) (am) (an) (ao) (ap) (aq) (ar) (as) (at) (au) (av) (aw) (ax) (ay) (az) (ba) (bb) (bc) (bd) (be) (bf) (bg) (bh) (bi) (bj) (bk) (bl) (bm) (bn) (bo) (bp) (bq) (br) (bs) (bt) (bu) (bv) (bw) (bx) (by) (bz) (ca) (cb) (cc) (cd) (ce) (cf) (cg) (ch) (ci) (cj) (ck) (cl) (cm) (cn) (co) (cp) (cq) (cr) (cs) (ct) (cu) (cv) (cw) (cx) (cy) (cz) (da) (db) (dc) (dd) (de) (df) (dg) (dh) (di) (dj) (dk) (dl) (dm) (dn) (do) (dp) (dq) (dr) (ds) (dt) (du) (dv) (dw) (dx) (dy) (dz) (ea) (eb) (ec) (ed) (ee) (ef) (eg) (eh) (ei) (ej) (ek) (el) (em) (en) (eo) (ep) (eq) (er) (es) (et) (eu) (ev) (ew) (ex) (ey) (ez) (fa) (fb) (fc) (fd) (fe) (ff) (fg) (fh) (fi) (fj) (fk) (fl) (fm) (fn) (fo) (fp) (fq) (fr) (fs) (ft) (fu) (fv) (fw) (fx) (fy) (fz) (ga) (gb) (gc) (gd) (ge) (gf) (gg) (gh) (gi) (gj) (gk) (gl) (gm) (gn) (go) (gp) (gq) (gr) (gs) (gt) (gu) (gv) (gw) (gx) (gy) (gz) (ha) (hb) (hc) (hd) (he) (hf) (hg) (hh) (hi) (hj) (hk) (hl) (hm) (hn) (ho) (hp) (hq) (hr) (hs) (ht) (hu) (hv) (hw) (hx) (hy) (hz) (ia) (ib) (ic) (id) (ie) (if) (ig) (ih) (ii) (ij) (ik) (il) (im) (in) (io) (ip) (iq) (ir) (is) (it) (iu) (iv) (iw) (ix) (iy) (iz) (ja) (jb) (jc) (jd) (je) (jf) (jg) (jh) (ji) (jj) (jk) (jl) (jm) (jn) (jo) (jp) (jq) (jr) (js) (jt) (ju) (jv) (jw) (jx) (jy) (jz) (ka) (kb) (kc) (kd) (ke) (kf) (kg) (kh) (ki) (kj) (kk) (kl) (km) (kn) (ko) (kp) (kq) (kr) (ks) (kt) (ku) (kv) (kw) (kx) (ky) (kz) (la) (lb) (lc) (ld) (le) (lf) (lg) (lh) (li) (lj) (lk) (ll) (lm) (ln) (lo) (lp) (lq) (lr) (ls) (lt) (lu) (lv) (lw) (lx) (ly) (lz) (ma) (mb) (mc) (md) (me) (mf) (mg) (mh) (mi) (mj) (mk) (ml) (mn) (mo) (mp) (mq) (mr) (ms) (mt) (mu) (mv) (mw) (mx) (my) (mz) (na) (nb) (nc) (nd) (ne) (nf) (ng) (nh) (ni) (nj) (nk) (nl) (nm) (nn) (no) (np) (nq) (nr) (ns) (nt) (nu) (nv) (nw) (nx) (ny) (nz) (oa) (ob) (oc) (od) (oe) (of) (og) (oh) (oi) (oj) (ok) (ol) (om) (on) (oo) (op) (oq) (or) (os) (ot) (ou) (ov) (ow) (ox) (oy) (oz) (pa) (pb) (pc) (pd) (pe) (pf) (pg) (ph) (pi) (pj) (pk) (pl) (pm) (pn) (po) (pp) (pq) (pr) (ps) (pt) (pu) (pv) (pw) (px) (py) (pz) (qa) (qb) (qc) (qd) (qe) (qf) (qg) (qh) (qi) (qj) (qk) (ql) (qm) (qn) (qo) (qp) (qq) (qr) (qs) (qt) (qu) (qv) (qw) (qx) (qy) (qz) (ra) (rb) (rc) (rd) (re) (rf) (rg) (rh) (ri) (rj) (rk) (rl) (rm) (rn) (ro) (rp) (rq) (rr) (rs) (rt) (ru) (rv) (rw) (rx) (ry) (rz) (sa) (sb) (sc) (sd) (se) (sf) (sg) (sh) (si) (sj) (sk) (sl) (sm) (sn) (so) (sp) (sq) (sr) (ss) (st) (su) (sv) (sw) (sx) (sy) (sz) (ta) (tb) (tc) (td) (te) (tf) (tg) (th) (ti) (tj) (tk) (tl) (tm) (tn) (to) (tp) (tq) (tr) (ts) (tt) (tu) (tv) (tw) (tx) (ty) (tz) (ua) (ub) (uc) (ud) (ue) (uf) (ug) (uh) (ui) (uj) (uk) (ul) (um) (un) (uo) (up) (uq) (ur) (us) (ut) (uu) (uv) (uw) (ux) (uy) (uz) (va) (vb) (vc) (vd) (ve) (vf) (vg) (vh) (vi) (vj) (vk) (vl) (vm) (vn) (vo) (vp) (vq) (vr) (vs) (vt) (vu) (vv) (vw) (vx) (vy) (vz) (wa) (wb) (wc) (wd) (we) (wf) (wg) (wh) (wi) (wj) (wk) (wl) (wm) (wn) (wo) (wp) (wq) (wr) (ws) (wt) (wu) (wv) (ww) (wx) (wy) (wz) (xa) (xb) (xc) (xd) (xe) (xf) (xg) (xh) (xi) (xj) (xk) (xl) (xm) (xn) (xo) (xp) (xq) (xr) (xs) (xt) (xu) (xv) (xw) (xx) (xy) (xz) (ya) (yb) (yc) (yd) (ye) (yf) (yg) (yh) (yi) (yj) (yk) (yl) (ym) (yn) (yo) (yp) (yq) (yr) (ys) (yt) (yu) (yv) (yw) (yx) (yy) (yz) (za) (zb) (zc) (zd) (ze) (zf) (zg) (zh) (zi) (zj) (zk) (zl) (zm) (zn) (zo) (zp) (zq) (zr) (zs) (zt) (zu) (zv) (zw) (zx) (zy) (zz)					
22b. SIGNATURE <b>DR. G. WARD</b>		22c. DATE SIGNED <b>6/18/81</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. G. WARD</b>	
22e. ADDRESS <b>6116 ROBINWOOD, Bethesda, MD 20814</b>		22f. DATE SIGNED <b>6/18/81</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>6-19-81</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lee's Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D.C. 20002</b>
24. FUNERAL DIRECTOR NAME <b>Lee Funeral Home 300-4th St. N.E. Wash. D.C.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 23 1981</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



DR. ROGERS NOTIFIED 11:40 A.M. - CLEAN PC  
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3a should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR						2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)						6-29-87		4:35 P.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
MALE		CAUCASIAN		6-6-XXXX		XX 76 YRS		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
OHIO		U.S.A.				Montgomery MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring		Holy Cross Hospital				PAINTER		SELF EMPLOYED			
13a. STATE						13b. CITY OR TOWN		13c. STREET ADDRESS			
MARYLAND						PRINCE GEO. LAUREL		9572 MUIRKIRK ROAD			
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME					
WALTER HASTINGS						EFFIE BOYER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)						16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
NO						268-14-8144		BEULAH E. CUMBERLAND SAME AS 13 SISTER			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) 5-188										72 hrs	
DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Lung Disease										3 yrs	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
Pulmonary Embolism											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
				HOUR A.M. MONTH DAY YEAR		fall from chair. no injury					
21d. INJURY OCCURRED				21e. PLACE OF INJURY		21f. LOCATION					
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK				HOSPITAL		Forest Glen Rd. Silver Spring, Mont. D. MD.					
22a. I certify that (I) (this hospital) attended the deceased from 7/20, 19 87, to 6/29, 19 87, that (I) (we) last saw the deceased alive on 6/29/87, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)											
22b. SIGNATURE						DEGREE		22c. DATE SIGNED			
Richard Croff						MD		6/30/87			
22b. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
R. Croff						10620 Ga. Ave Silver Spring					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. STATE	
BURIAL				7/2/87		PARKLAWN CEMETERY		ROCKVILLE		MONTGOMERY MD.	
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR					
NAME FRANCIS J. COLLINS						JUL 8 1987					
500 UNIV. BLVD., W. SILVER SPRING, MD. 20901						GISTRAR'S SIGNATURE					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR					8 1 1 6 3 0 4 CERTIFICATE OF DEATH				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
FIRST MIDDLE LAST					MONTH DAY YEAR				
2b. HOUR									
3. SEX					4. RACE				
5. DATE OF BIRTH					6. AGE (IN YEARS LAST BIRTHDAY)				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)					7b. CITIZEN OF WHAT COUNTRY?				
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH				
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE					13b. COUNTY				
13c. CITY OR TOWN					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				
13e. STREET ADDRESS					14. FATHER'S NAME				
15. MOTHER'S MAIDEN NAME					16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				
16b. SOCIAL SECURITY NO.					17. INFORMANT ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Intoxication PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Stroke					APPROVED BY PHYSICIAN BETWEEN 12:00 AM AND 12:00 PM Mentals yeme 11				
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				
21c. INJURY OCCURRED					21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				
21e. LOCATION STREET CITY OR TOWN COUNTY STATE					21f. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
22. I certify that (he/she) attended the deceased from 6/16/81 to 6/16/81 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated.					22a. SIGNATURE DEGREE				
22b. PHYSICIAN'S NAME (TYPE OR PRINT)					22c. DATE SIGNED				
22d. ADDRESS					22e. MEDICAL STAFF PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)					23b. DATE				
23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION CITY OR TOWN COUNTY STATE				
24. FUNERAL DIRECTOR					25a. DATE REC'D. BY REGISTRAR				
25b. REGISTRAR'S SIGNATURE					25c. REGISTRAR'S SIGNATURE				





Dr. Ball contacted, case turned over to attending physician

TO HOSPITAL OR ATTENDING PHYSICIAN: The attending physician is required to sign this certificate and the death certificate be executed within 24 hours after death. If the physician is retained by the hospital or attending physician.

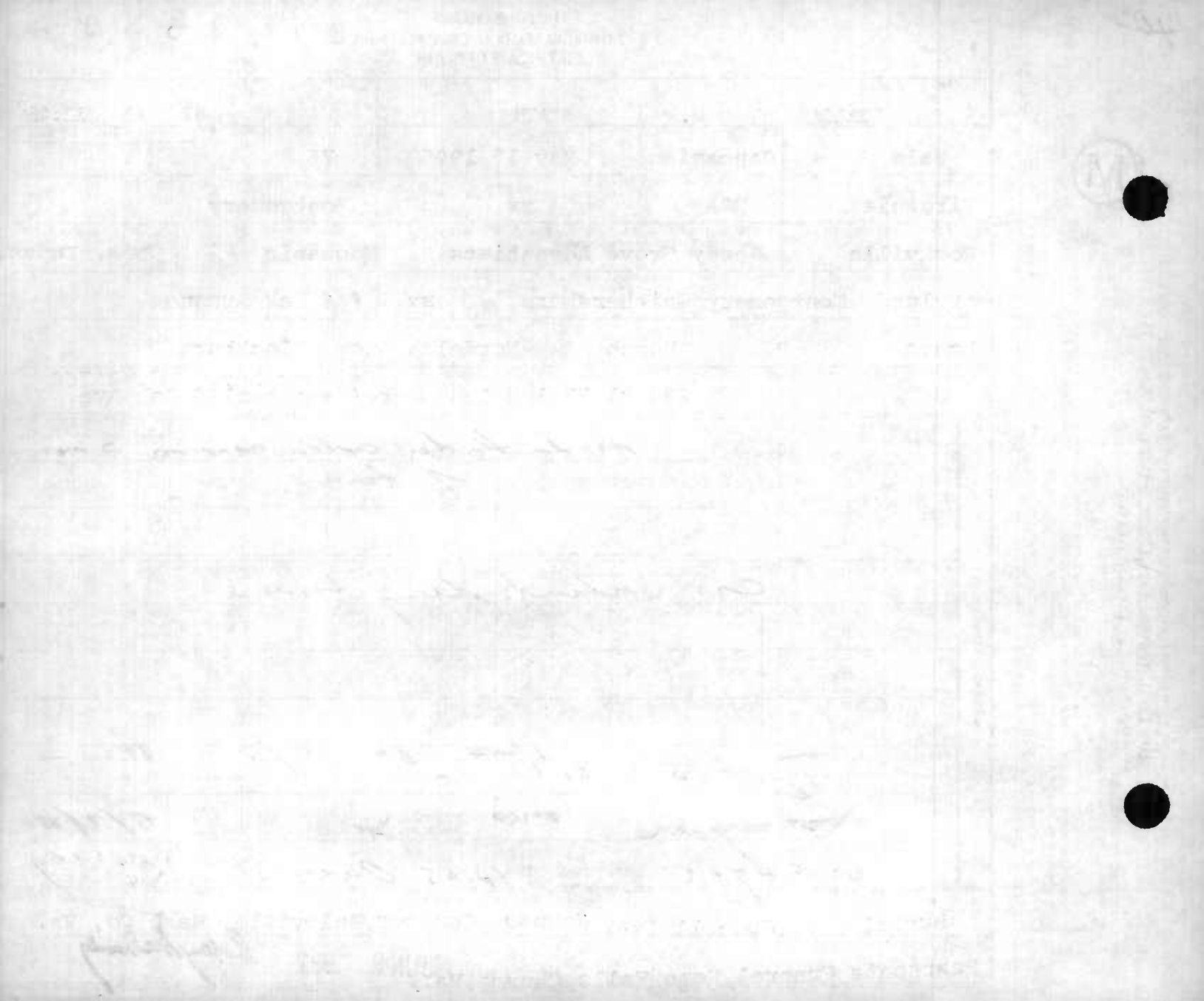
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
CERTIFICATE OF DEATH										
REG. NO.										
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM W. HEATH					2a. DATE OF DEATH MONTH DAY YEAR 06 07 81		2b. HOUR 12:45 PM			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR May 15 1905		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventists				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic		12b. KIND OF BUSINESS OR INDUSTRY Chem. Indus.		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY Maryland Montgomery					13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS # 6 Oak Avenue	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas R. Heath					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cordelia Lucy Blackburn					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 224 01 7781		17. INFORMANT ADDRESS Gaithersburg, Md. 20760 Helen Moore (daughter) #6 Oak Ave.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic adenocarcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>fatigue</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Ch. contract. lung disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Ch. contract. lung disease</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>4/28</u> 19 <u>80</u> to <u>6/2</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>6/15</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>[Signature]</u> DEGREE <u>MD</u>					22c. DATE SIGNED <u>6/2/81</u>			22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>G. R. [Signature]</u>		
22e. ADDRESS <u>12105 Oakcrest Rd Gaithersburg</u>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 11 1981		23c. NAME OF CEMETERY OR CREMATORY Johnson Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Saltville, Wash Co., Va.				
24. FUNERAL DIRECTOR NAME Pearson's Funeral Home Falls Church, Va.					25a. DATE REC'D. BY REGISTRAR JUN 9 1981					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use at the burial-transit permit. Their please remove certain papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be completed and given to the funeral director.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH			2b. HOUR	
FIRST MIDDLE LAST <u>Helen L Hebron</u>					MONTH DAY YEAR <u>6 26 81</u>			M	
2. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
<u>Female</u>		<u>Black</u>		MONTH DAY YEAR <u>12 14 13</u>		<u>67</u> YRS		MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
<u>MD.</u>		<u>U.S.A.</u>				<u>MONTGOMERY</u> MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
<u>Bethesda</u>		<u>Suburban Hospital</u>							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS?				
13a. STATE					13b. COUNTY				
<u>MD.</u>					<u>MONTG.</u>				
13c. CITY OR TOWN					13e. STREET ADDRESS				
<u>ROCKVILLE</u>					<u>215 ASHLEY AVE</u>				
14. FATHER'S NAME (TYPE OR PRINT)					15. MOTHER'S MAIDEN NAME (TYPE OR PRINT)				
FIRST MIDDLE LAST <u>HARRY GREEN</u>					FIRST MIDDLE LAST <u>LILLIE WINDEAR</u>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		
<u>No</u>					<u>217-30-1105</u>		<u>Elizabeth Young (daughter)</u>		
							<u>613 N. Stonest</u> <u>Rockville, Md</u>		
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>									
4100 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) <u>severe acute myocardial infarction</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c) <u>coronary artery disease</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
<u>diab mellitus</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>June 26</u> , 19 <u>81</u> , to <u>June 26</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>June 26</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE			22c. DATE SIGNED	
<u>Mary Fang, M.D.</u>								<u>6/26/81</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
<u>Mary Fang</u>					<u>11004 Roundtable Ct.</u> <u>Rockville, Md. 20852</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
<u>BURIAL</u>			<u>7-1-81</u>		<u>Lincoln Park Cem.</u>		<u>Rockville Montg Md.</u>		
24. FUNERAL DIRECTOR NAME					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
<u>George R. Snowden</u> <u>246 N. Wash. St.</u> <u>Rockville, Md.</u>					<u>JUL 2 1981</u>		<u>Dorothy McCarty</u>		

BP

FORM 1-16 50M 1/81  
(VRA 15, 4)



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.		8 1 1 6 3 0 1					
1. DECEASED NAME (TYPE OR PRINT) <b>PHILIP</b> <b>HELMAN</b>				7a. DATE OF DEATH MONTH DAY YEAR <b>6-14-81</b>				7b. HOUR <b>8:25</b> P.M.	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JULY 19, 1906</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MASSACHUSETTS</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>ACCOUNTANT</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>SELF EMPLOYED</b>	
13a. STATE <b>MASSACHUSETTS</b>				13b. CITY OR TOWN <b>MIDDLESEX</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>293 TURNPIKE ROAD</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>SAMUEL</b> <b>HELMAN</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>PAULINE</b> <b>SONDLICK</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>022-10-6059</b>		17. INFORMANT ADDRESS <b>DAVID HELMAN, 562 EDWARDS DRIVE, ODENTON, MARYLAND</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOGENIC SHOCK</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>MYOCARDIAL INFARCTIONS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>CORONARY ARTERY DISEASE</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>36 hours</b> <b>13 days and 36 hours</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>NONE</b>									
19a. DATE OF OPERATION <b>NONE</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NONE</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>N/A</b> <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>N/A</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> <b>N/A</b>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>N/A</b>		21f. LOCATION STREET <b>N/A</b>		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>6/2</b> , 19 <b>81</b> , to <b>6/14</b> , 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>6/14</b> , 19 <b>81</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Alan N. Schulman</b>				DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>6/14/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ALAN N. SCHULMAN, M.D.</b>				22e. ADDRESS <b>9715 MEDICAL CENTER DRIVE SUITE 404, ROCKVILLE, MD. 20850</b>					
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		23b. DATE <b>JUNE 17, 1981</b>		23c. NAME OF CEMETERY OR CREMATOR <b>KEHELLETH JACOB CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>WEST ROXBURY MASS.</b>			
24. FUNERAL DIRECTOR NAME <b>DONALD M. STEIN</b>				HEBREW MEMORIAL FUNERAL HOME <b>232 CARROLL STREET, N. W., WASHINGTON, D. C.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 18 1981</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

BP



JUL 2 1961

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 6 3 0 8

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Bernard A. Hermann			2a. DATE OF DEATH MONTH DAY YEAR June 8, 81		2b. HOUR 10:48 PM
3. SEX male	4. RACE caucasian	5. DATE OF BIRTH MONTH DAY YEAR 4 7 98	6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman	12b. KIND OF BUSINESS OR INDUSTRY Clothing	
13a. STATE Maryland			13b. COUNTY Montgomery	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sophie Robiniwitz		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWI 102-07-0288	17. INFORMANT ADDRESS Anna S. Hermann (Same as 13e)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock syndrome / Lactic acidosis DUE TO, OR AS A CONSEQUENCE OF (b) Occlusion of venous return + ? arterial (c) Histiocytic lymphoma CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 hours 2-3 days 7-6 months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Mild renal insufficiency, Benign prostatic hypertrophy					
19a. DATE OF OPERATION 6/1/81	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Mass (R) LG Quadrant.	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE 11510 Old Georgetown Rd Rockville, MD			
22a. I certify that (I) (this hospital) attended the deceased from 4/70 to 6/81, that (I) (we) last saw the deceased alive on 6/81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Thomas G. Garvey II, MD	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 6/5/81		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS G. GARVEY II, MD	22e. ADDRESS 11510 Old Georgetown Rd Rockville, MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE June 1, 1981	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Silver Springs Maryland		
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey's Funeral Homes P.A., Rockville, Maryland		25a. DATE REC'D. BY REGISTRAR JUN 15 1981			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR										816309	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>NICHOLAS (NMN) HERNICK, Jr.</b>										2a. DATE OF DEATH KNOWN ESTIMATED MONTH DAY YEAR <b>6 27 1981</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 4, 1925</b>		6. AGE (IN YEARS) (LAST BIRTHDAY) YEARS MONTHS DAYS <b>56</b>		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>June 27 1981</b>		2b. HOUR <b>1:22 AM</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Gaithersburg</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Shady Grove Adventist Hosp</b>				12a. USUAL OCCUPATION (TYPE OF WORK) <b>Power Plant Operator</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>P.E.P. Co.</b>	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Takoma Park</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>6812 10th Avenue</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Nicholas Hernick</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Pauline Unknown</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. <b>WW 11</b>		17. INFORMANT ADDRESS <b>Catherine K. Hernick Same as #13 (Wife)</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fracture and Contusion of Cervical Spine</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>Trauma, Auto Accident</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR AM MONTH DAY YEAR <b>11:20 P.M. 6 26 1981</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>Passenger in auto in head on collision</b>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Highway</b>				21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Route 28 near Orchard Gaithersburg Mont. Md.</b>			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <b>John G. Ball</b>				TITLE (SPECIFY) <b>M.D. Deputy</b>				MEDICAL EXAMINER <b>John G. Ball, M.D.</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>John G. Ball, M.D.</b>				ADDRESS <b>7936 Old Georgetown Rd. Beth, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>6/30/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring Mont. Md.</b>	
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Funeral Home, P.A. Hyattsville, Maryland</b>						25a. DATE REC'D. BY REGISTRAR <b>JUN 30 1981</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

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• **How to use:** By mail-order only. In stock.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) First Middle Last <b>John M. Higgins</b>					2a. DATE OF DEATH Month Day Year <b>June 22 1981</b>			2b. HOUR <b>4:30 PM</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Dec. 18, 1909</b>		6. AGE (In years last birthday) <b>71</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <b>Ohio</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b>				
10. CITY OR TOWN OF DEATH <b>Gaithersburg</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>11910 Darnestown Rd.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Ret'd Contractor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Gaithersburg</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>11910 Darnestown Rd.</b>	
14. FATHER'S NAME First Middle Last <b>Joseph Taylor Higgins</b>					15. MOTHER'S MAIDEN NAME First Middle Last <b>Mary - Gorman</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>			16b. SOCIAL SECURITY NO. <b>576-10-7502</b>		17. INFORMANT <b>Mrs. Edith Higgins 11910 Darnestown Rd., Gaithersburg, Md. 20760</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> <b>4960</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cardio Vascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>COPD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2-3 hrs</b> <b>2-3 yrs</b> <b>2-3 yrs</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Alcohol Abuse</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>1975</b> , to <b>June 22, 1981</b> , that (I) (we) last saw the deceased alive on <b>June 2, 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Ronald E. Greger, M.D.</b>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>June 24, '81</b>			
22d. PHYSICIAN'S NAME (Type) <b>Ronald E. Greger, M.D.</b>					22e. ADDRESS <b>Quince Orchard Med. Center 12105 Darnestown Rd., Gaithersburg, Md.</b>					
23a. BURIAL, CREMATION, MOVAL (Specify) <b>Burial</b>		23b. DATE <b>6/25/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Rockville, Montgomery, Md.</b>			
24. BY SPECIAL REGISTRAR <b>Gartner Sandison 316 E. Diamond Ave., Gaithersburg, Md.</b>					25a. JUDICIAL REGISTRAR DATE...		25b. REGISTRAR'S SIGNATURE <b>JUN 26 1981</b>			

TO : DIRECTOR, FBI (100-388610)  
FROM : SAC, NEW YORK (100-100000) (P)  
SUBJECT: [Illegible]  
RE: [Illegible]  
[Illegible text follows, appearing to be a memorandum or report with several paragraphs of text, mostly obscured by heavy noise and bleed-through from the reverse side of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
CERTIFICATE OF DEATH										
REG. NO.										
1. FOR STATE REGISTRAR			2a. DECEASED NAME (TYPE OR PRINT)				2b. DATE OF DEATH		2c. HOUR	
			Dorothy Hines				6 4 81		2:00 AM	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS (LAST BIRTHDAY))		7. IF UNDER 1 YEAR		
Female		White		Sept 1, 1910		70		MONTHS DAYS HOURS MIN.		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		9. CITIZEN OF WHAT COUNTRY?		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH		12. IF UNDER 24 HRS		
Maryland		USA				Montgomery		MONTHS DAYS HOURS MIN.		
13. CITY OR TOWN OF DEATH		14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION				15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		16. KIND OF BUSINESS OR INDUSTRY		
Olney		Montgomery General Hospital				Housewife		Home		
17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			18. CITY OR TOWN			19. INSIDE CITY LIMITS?			20. STREET ADDRESS	
Md Howard			Laurel			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			10504 Scaggsville Road	
21. FATHER'S NAME			22. MOTHER'S MAIDEN NAME			23. ADDRESS			24. ADDRESS	
John T. Hill			Christine Kruhm							
25. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			26. SOCIAL SECURITY NO.			27. INFORMANT			28. ADDRESS	
no			218-38-9094			Carlton W. Hines same as above				
29. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <i>Granulosa cell carcinoma (R) ovary</i>										
1830 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										
(b) DUE TO, OR AS A CONSEQUENCE OF										
(c) DUE TO, OR AS A CONSEQUENCE OF										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):										
<i>Intractable intestinal metastasis &amp; multiple small bowel obstruction. (L) pleural metastasis</i>										
30. DATE OF OPERATION			31. CONDITION FOR WHICH OPERATION WAS PERFORMED			32. AUTOPSY?		33. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
34. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			35. TIME OF INJURY			36. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
			HOUR A.M. MONTH DAY YEAR							
			P.M. 19							
37. INJURY OCCURRED			38. PLACE OF INJURY			39. LOCATION				
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>			(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			STREET CITY OR TOWN COUNTY STATE				
40. I certify that (I) (this hospital) attended the deceased from <i>Jan 1981</i> to <i>4 June 1981</i> that (I) (time) last saw the deceased alive on <i>3 June 81</i> 19 <i>81</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
41. SIGNATURE						42. DEGREE		43. DATE SIGNED		
<i>Donald E. Dillon MD</i>						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		<i>4 June 81</i>		
44. PHYSICIAN'S NAME (TYPE OR PRINT)						45. ADDRESS				
Donald E. Dillon						Prince Philip Dr., Olney, Md				
46. BURIAL, CREMATION, REMOVAL (SPECIFY)			47. DATE		48. NAME OF CEMETERY OR CREMATORY		49. LOCATION			
Burial			June 6, 1981		Emmanuel Cemetery		Scaggsville, Maryland STATE			
50. FUNERAL DIRECTOR						51. DATE REC'D. BY REGISTRAR		52. REGISTRAR'S SIGNATURE		
Donaldson Funeral Home, Laurel, Md						JUN 9 1981		<i>Robert H. Hines</i>		

MEDICAL CERTIFICATION

John L. Hill

Christine Adams

Lowry

Laurel

1934-1935

John L. Hill

Lowry

Lowry

Lowry

Lowry

Sept 1, 1910

Lowry

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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FOR  
1. STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 6 3 1 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MILTON T HOGAN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6/28/81</b>			2b. HOUR <b>6 AM</b>			
3. SEX <b>male</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 1 20</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>60</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD.</b>			
10. CITY OR TOWN OF DEATH <b>FAKOMA PARK</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WASHINGTON ADVENTIST HOSP.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Plumbing &amp; Electrical</b>			
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>PRINCE GEORGES</b>		13c. CITY OR TOWN <b>LAUREL</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1113 MONTROSE AVENUE</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>HARRY HOGANS</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANNA R COOPER</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> (YES GIVE YEAR OR DATES) <b>WW 2</b>			
16b. SOCIAL SECURITY NO. <b>218-09-7524</b>			17. INFORMANT <b>Margaret Hogans</b>			ADDRESS <b>Montrose Ave Laurel, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial infarction</b> <b>1629</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>JANUARY 19, 1981</b> to <b>JUNE 28, 1981</b> , that (I) (we) lost <b>saw the deceased alive on JUNE 28, 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) visit the body after death.									
22b. SIGNATURE <b>[Signature]</b>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>6/29/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LEWIS H. DENNIS, MD., P.A.</b>			22e. ADDRESS <b>831 UNIVERSITY BLVD, EAST SILVER SPRING, MD. 20903</b>						
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>			23b. DATE <b>7/2/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Still Pond Cem</b>		23d. LOCATION <b>Still Pond, Md.</b> STATE		
24. FUNERAL DIRECTOR <b>Willis Wells - Chestertown, Md.</b>					25a. DATE REC'D. BY REGISTRAR <b>JUL 1 - 1981</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		



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Page 4 may be retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) EDNA M HOWARD			2a. DATE OF DEATH MONTH DAY YEAR 6 28 81			2b. HOUR 10:15 AM				
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 8 27 87		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Wash. D.C.			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13d. STREET ADDRESS 5415 Conn. Ave. N.W.	
14. FATHER'S NAME FIRST MIDDLE LAST Franklin V. Hillyard			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Jane Riley							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 578 03 4549			17. INFORMANT 2305 Sherbrooke Way William J. Howard Jr. Rockville Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 4360 DUE TO, OR AS A CONSEQUENCE OF Left hemiplegia (b) 9 days (c) DUE TO, OR AS A CONSEQUENCE OF Cerebral Arteriosclerosis									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): Arteriosclerotic Heart Disease										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) <input checked="" type="checkbox"/> this hospital attended the deceased from 6/27/81 to 6/28/81, that (I) <input checked="" type="checkbox"/> saw the deceased alive on 6/27/81 and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above; (I) <input type="checkbox"/> did not view the body after death.										
22b. SIGNATURE J. Blaine Fitzgerald M.D.			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 6/28/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Blaine Fitzgerald, M.D.			22e. ADDRESS 8218 Wisc. Ave. Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE July 1, 1981			23c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet			23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.	
24. FUNERAL DIRECTOR W.W. Taltavull 4748 Wisc. Ave. N.W. Wash. D.C.			25a. DATE REC'D. BY REGISTRAR JUL 1 1981			25b. REGISTRAR'S SIGNATURE				

Wash. D.C.

Suburban Hospital

Homewood

Wash. D.C.

XX

2412 Conn. Ave. N.W.

Franklin W. Halliday

Harry Lane Wiley

2302 Woodrooke Way

4203 03 Washington L. Howard Dr. No

Rockville

J. Elaine Pittsford, M.D. 8218 Wood. Ave. Bethesda, Md.

XXXXXX

Washington, D.C.

1011 Mt. Olivet

F.W. Talbot

4048 Wood. Ave. N.W. Wash. D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 6 3 1 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ALICE G HOYT</b>			2a. DATE OF DEATH MONTH <b>6</b> DAY <b>5</b> YEAR <b>81</b>			2b. HOUR <b>9:05</b> P.M.		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>03</b> DAY <b>14</b> YEAR <b>12</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.		
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOLY CROSS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>California</b>		13b. COUNTY <b>Riverside</b>		13c. CITY OR TOWN <b>Riverside</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>5651 Camino Real</b>
14. FATHER'S NAME (FIRST MIDDLE LAST) <b>Michael St. John</b>				15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) <b>Jennie Mahoney</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>531-01-7020</b>		17. INFORMANT ADDRESS <b>Wayland H. Hoyt Same as 13e</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiac arrest</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>acute myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 min</b> <b>19 days</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>metastatic breast carcinoma</b>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from <b>6/5/81</b> , 19 <b>81</b> , to <b>6/5</b> , 19 <b>81</b> , that (1) (we) last saw the deceased alive on <b>never</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) not view the body after death.								
22b. SIGNATURE <b>Mark Rosen</b>				DEGREE <b>Attending Physician</b>		22c. DATE SIGNED <b>6/7/81</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Mark Rosen</b>
22e. ADDRESS <b>Silver Spring</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>June 8, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan Crematory Alexandria Va</b>		23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME <b>Francis J. Collins</b>				ADDRESS <b>Funeral Home, Inc. Silver Spring Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 12 1981</b>		

BP

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1891.8 2007

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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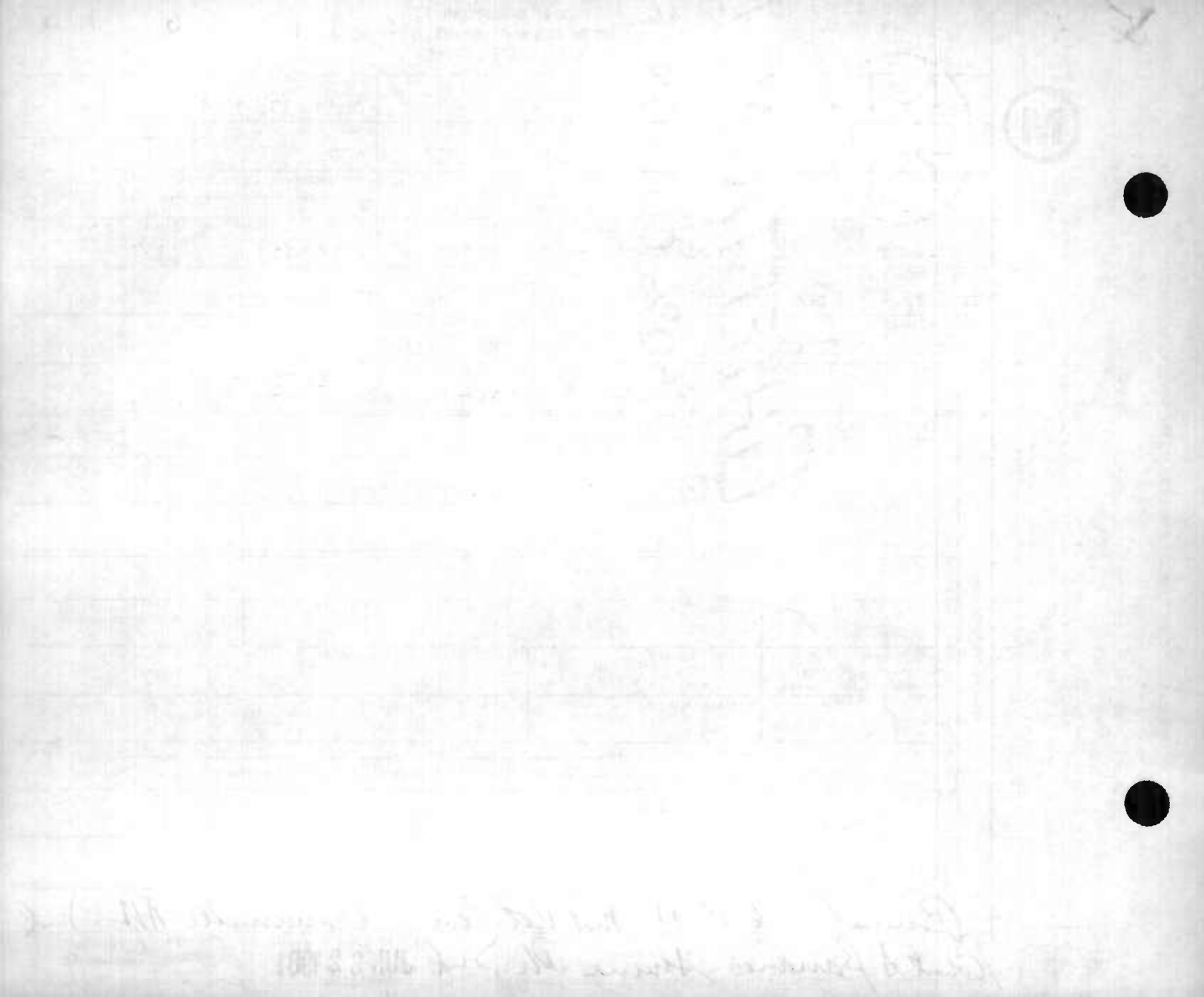
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Mary Eleanor HUGHES</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>June 17, 1981</b>			2b. HOUR <b>0604 a.m.</b>				
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 29, 1924</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>57</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S. Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY COUNTY</b> MD.				
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>National Naval Medical Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Severna Park</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>17 River Drive</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Curtis CANFIELD</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ruth BELL</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>248-28-8209</b>		17. INFORMANT ADDRESS <b>Jerome M. Hughes 17 River Drive Severna Park, Md.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>EXSANGUINATION</b> <b>1579</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>LIVER AND/OR PANCREATIC BIOPSY</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>PANCREATIC CANCER</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Mark D. Browning</i>				DEGREE				22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Mark D. Browning MD</b>				22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE <b>6-19-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Nat. Vet. Cem</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Crownsville AN MD</b>				
24. FUNERAL DIRECTOR NAME <b>Count J. Baranow</b>				ADDRESS <b>Severna Park, Md</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 22 1981</b>		25b. REGISTRAR'S SIGNATURE <i>Anthony M. Browning</i>		





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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BP

DHMH-1650M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>JOHN MILTON HYDE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JUNE 6, 1981</b>			2b. HOUR <b>1517 P M</b>									
3. SEX <b>MALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>SEPT 6, 1910</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS		IF UNDER 1 YEAR MONTHS DAYS <b>9</b>		IF UNDER 24 HRS HOURS MIN. <b></b>					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY MD.</b>									
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NATNAVMEDCEN BETHESDA MD</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED OFFICER</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>US NAVY</b>						
13a. STATE <b>VIRGINIA</b>			13b. COUNTY <b>FAIRFAX</b>		13c. CITY OR TOWN <b>VIENNA</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET ADDRESS <b>2800 EVELYN COURT</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>EDWARD BOLTON HYDE</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY L. BEARDSLEY</b>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>YES 1934-1964</b>				16b. SOCIAL SECURITY NO. <b>420-52-5023</b>		17. INFORMANT * ADDRESS <b>VERNA HYDE, 2800 EVELYN COURT, VIENNA VA</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BILATERAL NECROTIZING BRONCHO PNEUMONIA AND EMBOLI</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>GLIOLBLASTOMA MULTIFORM</b>															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>MARCH 19</b> 19 <b>81</b> to <b>JUNE 6</b> 19 <b>81</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>JUNE 6</b> 19 <b>81</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) did (did not) view the body after death.															
22b. SIGNATURE <i>[Signature]</i>						DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>8 June 81</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R. Lindsay Lilly, Jr. LCO(RMC)USN</b>						22e. ADDRESS <b>National Naval Medical Center, Bethesda, MD</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>6/11/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arl. Nat'l. Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington, Va.</b>							
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b> NAME ADDRESS <b>5130 Wisc. Ave. N.W. Wash., D.C.</b>						25a. DATE REC'D. BY REGISTRAR <b>JUN 11 1981</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>							

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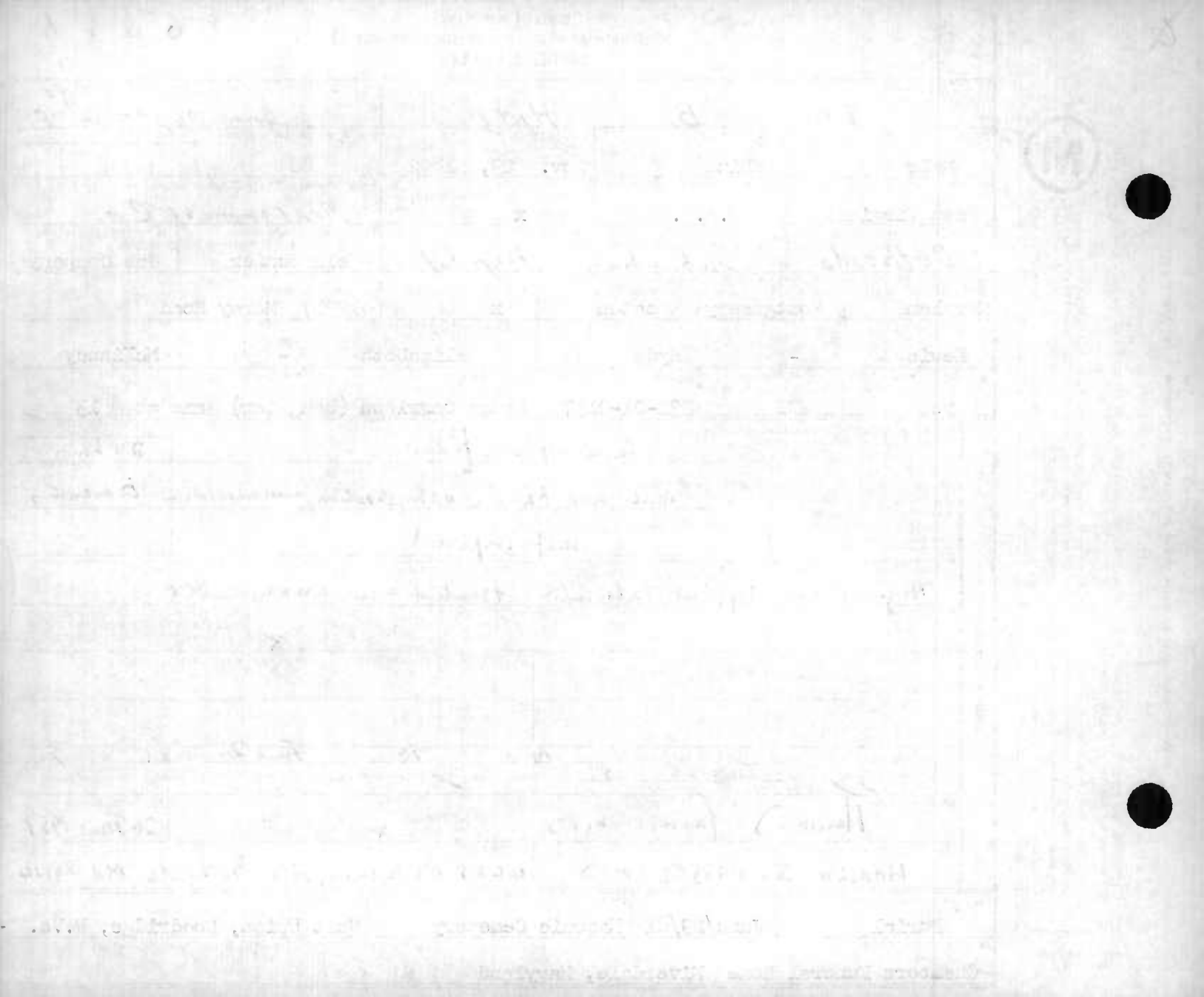
1950 1st Ave. N.W. Wash., D.C.  
The American Telephone & Telegraph Company  
Long Distance Department

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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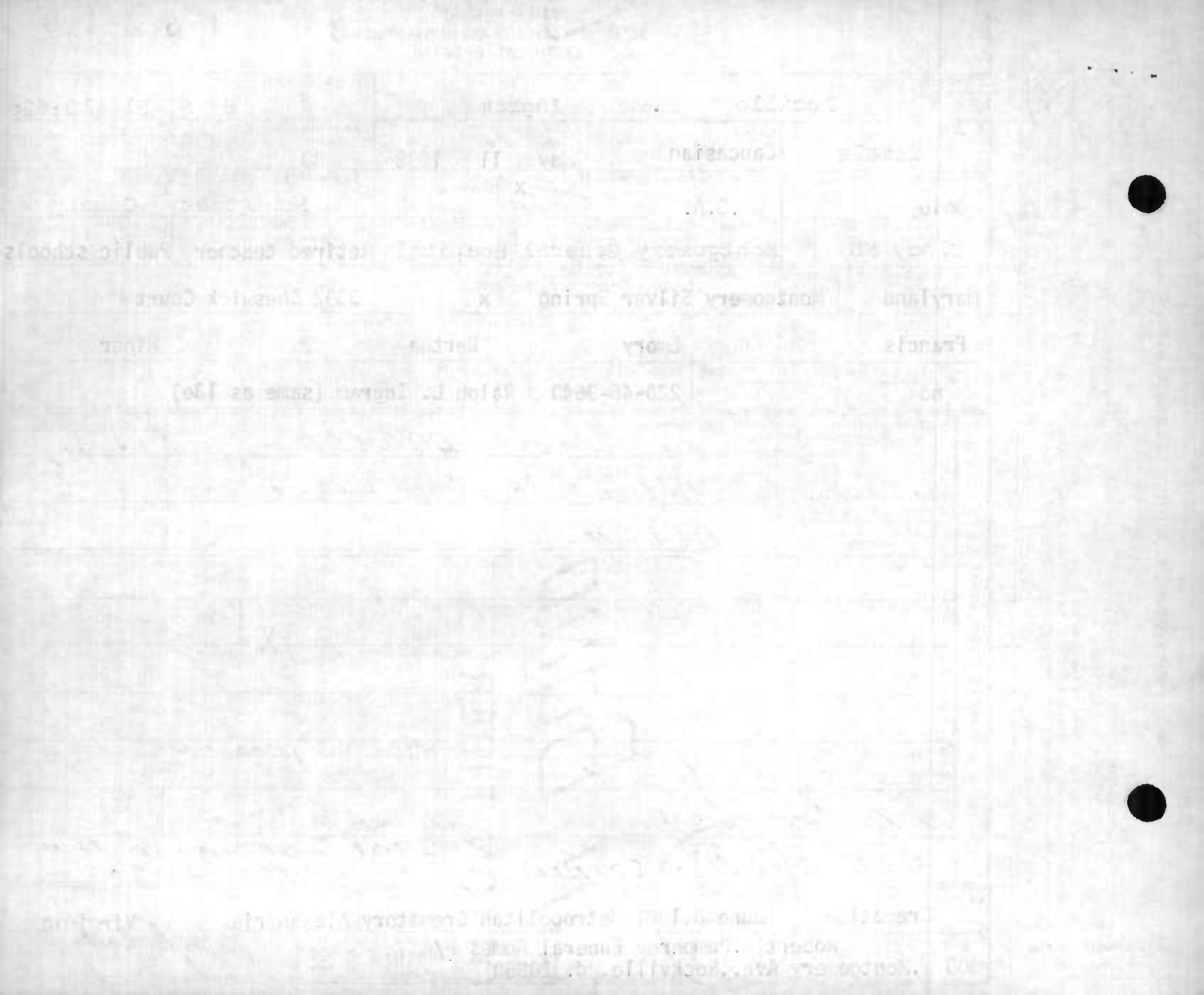
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR					8 1 1 6 3 1 7 CERTIFICATE OF DEATH				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
FIRST MIDDLE LAST <i>Ira B. Hyde</i>					MONTH DAY YEAR HOUR <i>June 26, 1981 2:45 P.M.</i>				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Male		White		MONTH DAY YEAR Nov. 29, 1892		88 YRS.		MONTHS DAYS HOURS MIN.	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7c. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
West Virginia		U.S.A.				Montgomery Co. MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda		Suburban Hospital				Well Tender		Gas Company	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS		
13a. STATE COUNTY Maryland Montgomery Wheaton					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		12917 Moray Road		
14. FATHER'S NAME FIRST MIDDLE LAST Lewis - Hyde					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth - McKinney				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) yes WWI					16b. SOCIAL SECURITY NO. 232-01-0137		17. INFORMANT ADDRESS Laura Garrison (Daughter) Same as # 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiovascular failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Acute and chronic dehydration and emaciation</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>self imposed</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <i>Atypical and Typical Tuberculosis treated - non communicable -</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>April</i> 19 <i>78</i> to <i>June 26</i> 19 <i>81</i> , that (I) (we) lost saw the deceased alive on <i>June 25</i> 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <i>Harold I. Passes M.D.</i> DEGREE					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>26 June 1981</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>HAROLD I. PASSES M.D.</i>					22e. ADDRESS <i>4425 Montgomery Ave Bethesda Md 20814</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>June/29/81</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Masonic Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>West Union, Doddridge, W.Va.</i>			
24. FUNERAL DIRECTOR NAME ADDRESS <i>Chambers Funeral Home Riverdale, Maryland</i>					25a. DATE REC'D. BY REGISTRAR <i>JUL 1 1981</i>		25b. REGISTRAR'S SIGNATURE <i>Harold I. Passes</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires; that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE																
1. FOR STATE REGISTRAR																
CERTIFICATE OF DEATH																
REG. NO.																
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR			
Lucille H. Ingram					6		6		81		10:42p					
3 SEX			4 RACE		5. DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			IF UNDER 24 HRS		
female			Caucasian		May 11 1898			83			MONTHS			DAYS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH							
Ohio			U.S.A.						Montgomery County MD							
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Olney MD			Montgomery General Hospital						Retired teacher			Public schools				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13b. CITY OR TOWN					13c. STREET ADDRESS						
Maryland					Montgomery					Silver Spring						
14 FATHER'S NAME					15. MOTHER'S MAIDEN NAME											
Francis					Bertha					Miner						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.					17 INFORMANT ADDRESS						
no					220-46-9640					Ralph L. Ingram (same as 13e)						
18 CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>										1 day						
4140 DUE TO, OR AS A CONSEQUENCE OF																
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										b) <u>Arteriosclerosis of Heart</u>						
										c) <u>DISEASE</u>						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:																
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 19 <u>78</u> to <u>present</u> , that (I) (we) lost saw the deceased alive on <u>6/14</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE										DEGREE		22c. DATE SIGNED				
<u>Alberto Rotsztein</u>																
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS						
ALBERTO ROTSTEIN										3701 Rossmore Blvd S. Spring Md 20906						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)					23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE						
Cremation					June 8, 1981		Metropolitan Crematory			Alexandria Virginia						
24. FUNERAL DIRECTOR NAME										25a. DATE REC'D. BY REGISTRAR						
Robert A. Pumphrey, Funeral Homes P/A 300 W. Montgomery Ave., Rockville, Md. 20850										JUN 15 1981						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		8 1 1 6 3 1 9									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
IRVING, JAMES K.						JAMES K. IRVING		6 - 27 - 81		2:35 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
MALE		WHITE		MONTH DAY YEAR 12 07 14		66		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Canada		Canada				MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda		SUBURBAN HOSPITAL						RETIRED		printing	
13a. STATE 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? 13e. STREET ADDRESS											
MARYLAND		MONTGOMERY		ROCKVILLE		YES <input type="checkbox"/> NO <input type="checkbox"/>		T #11 257 CONGRESSIONAL LANE			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Robert Irving				Ethel Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
no				220-56-6566		Judith L. Irving 2028 Dundee Rd. Rockville, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiogenic Shock</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Artery Atherosclerosis</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u> <u>Days</u> <u>years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>4100</u>											
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital attended the deceased from <u>Sept 22</u> , 19 <u>72</u> , to <u>June 27</u> , 19 <u>81</u> , that (I) lost saw the deceased alive on <u>June 27</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Harris M. Kenner</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>6/27/81</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Harris M. Kenner				22e. ADDRESS 10401 Old Georgetown Rd. Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Cremation				6/29/81		Metropolitan Crematory		Alexandria, Virginia			
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Maryland				JUL 1 1981				<u>[Signature]</u>			



1551 Rockville Pike Rockville, Maryland  
 Tyson Wheeler Funeral Home, Inc.

Organization 6/29/61 Metropolitan Crematory Alexandria, Virginia  
 Harris M. Kerner 10001 Old Georgetown Rd. Bethesda, Md.

no

250-58-6566 Death I. Irving; 2025 Dundee Rd.

Robert

Irving

Unknown  
 Rockville, Maryland

Robert

MONTGOMERY ROCKVILLE

253 CONGRESSIONAL LANE

Bedheads

SUBURBAN HOSPITAL

RETIRED

printing

Canada

Canada

MONTGOMERY

WHITE

WHITE

12

07

19

62

IRVING JAMES K. IRVING

6-27-61

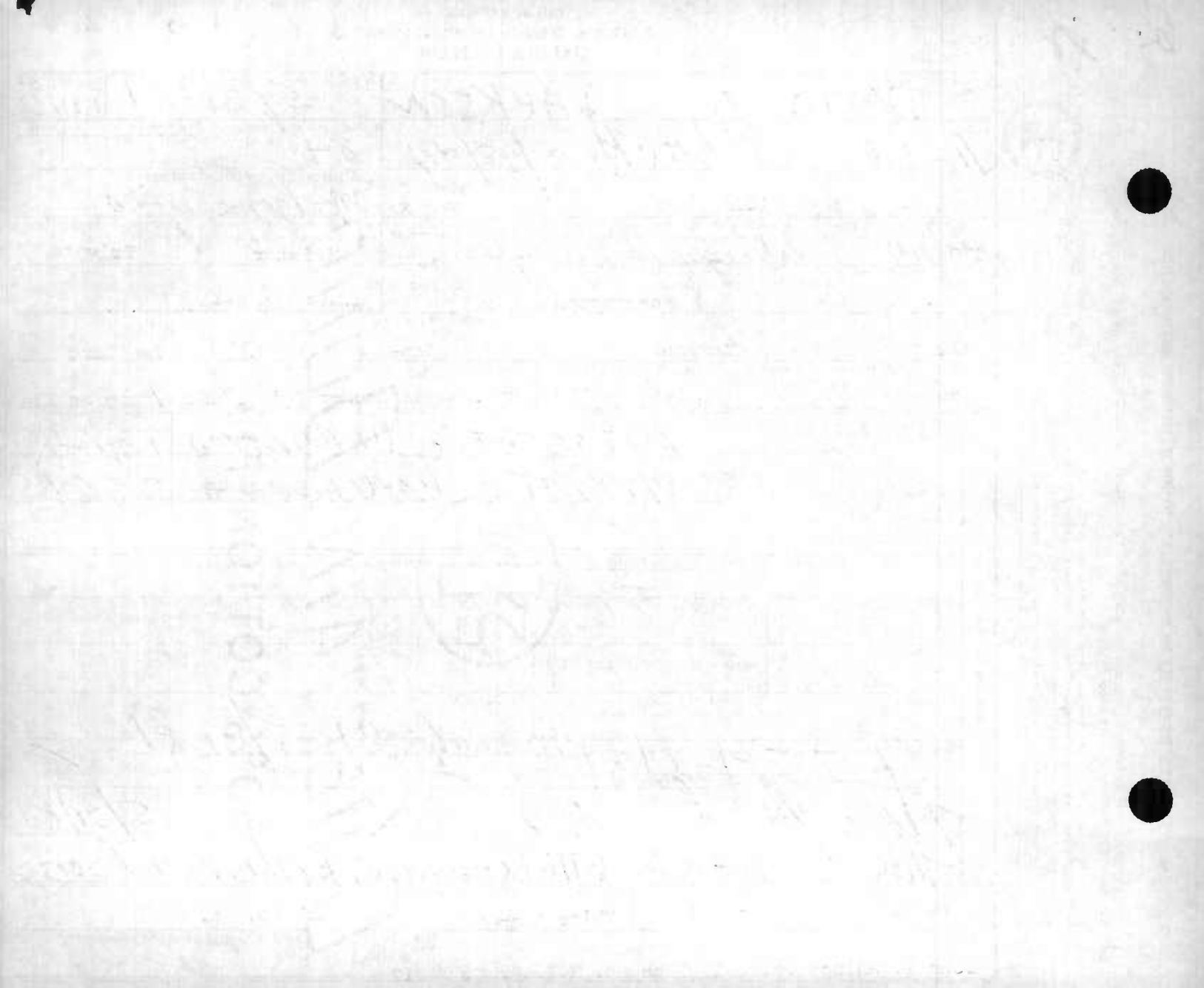
2135P

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 6 3 2 0			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>DAVID S JACKSON</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>5/31/81</b>		2b. HOUR <b>1240 P</b>	
3. SEX <b>MALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2/18/94</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S. C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery Co</b> MD.	
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Collegewood Nursing Center</b>		12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) <b>Minister</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Private</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>D. C.</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Washington</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Albert Jackson</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Jane M. Leophart</b>		17. INFORMANT ADDRESS <b>6101 16th Street, N.W.</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>148-05-7110</b>		17. INFORMANT ADDRESS <b>Mrs. Mamie Jackson Simms/niece/same as 13e</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>PROSTATIC CARCINOMA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>1850</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 YEAR</b> <b>3 YEARS</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>5/31/81</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>MAR 68, 81 5/31/81</b>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>6116 Robinwood, Bethesda, Md 20834</b>		21g. DATE SIGNED <b>5/31/81</b>	
22a. I certify that (I) (the hospital) attended the deceased from <b>5/31/81</b> and that (I) (we) last saw the deceased alive on <b>5/31/81</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.				22b. SIGNATURE <b>Thos G. Ward MD</b>		22c. DATE SIGNED <b>5/31/81</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6-6-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>White Chapel</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Buck Co, Pa.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>John T. Rhines Co., 3015 12th St., N.E., D. C. 20017</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 12 1981</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



## CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Doris ALVIN JESTER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6 27 81</b>			2b. HOUR <b>7 P.m.</b>				
3 SEX <b>FEMALE</b>		4 RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>DEC 6, 1917</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>63</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>63 XXX</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WASHINGTON, D. C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.				
10 CITY OR TOWN OF DEATH <b>TAKOMA PARK</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WASHINGTON ADVENTIST HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>TAKOMA PARK</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>8506 HASKIN PLACE</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>WALTER DICKHAUT</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANNA MAY BLACKMAN</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>579-16-4225</b>		17 INFORMANT <b>BROTHER MILTON A. DICKHAUT</b>		ADDRESS: <b>1407 NOYES DRIVE SILVER SPRING, MD.</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio Respiratory Arrest</b> <b>4360</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebrovascular accident</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Respiratory insufficiency</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>6/26/81</b> 19 <b>81</b> , to <b>6/27/81</b> 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>6/27/81</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Tony P. Kannarkat</b>			DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>6/27/81</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Tony P. Kannarkat</b>			22e. ADDRESS <b>8201 16th St S.S. MD 20910</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>7/1/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>SILVER SPRING MONT MD.</b>			
24 FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b> ADDRESS <b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>					25a. DATE REC'D. BY REGISTRAR <b>JUN 30 1981</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified to examine the body.

FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 6 3 2 2			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
Andrew Jr Johnson				June 11, 1981				5:35 A			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		CAUCASIAN		December 12, 1904		76 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Georgia		United States				Montgomery County, MD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Rockville		Shady Grove Adventist Hospital				Rate Clerk		Southern Railway			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland		Montgomery		Gaithersburg		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		446 Girard St. (apt. #202)			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
George Johnson				Petrae Albrecht							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No				704-18-1881		Kathryn S. Johnson (Same as 13e)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>septic shock</u>										days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										1 mo	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>pneumocystis</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) <u>lung cancer</u>										mos	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
				P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>6/10</u> 19 <u>81</u> , to <u>6/11</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>6/10</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
<u>John R. Melnich</u>				MD						<u>6/11/81</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
<u>John R. Melnich</u>				<u>16220 Frederick Rd - Gaithersburg, Md</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
BURIAL		June 15, 1981		Washington Nat. Cem.		Suitland		Maryland			
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Robert A. Pumphrey Funeral Homes, P.A. Rockville, Maryland				JUN 19 1981				<u>Liskey McBrady</u>			





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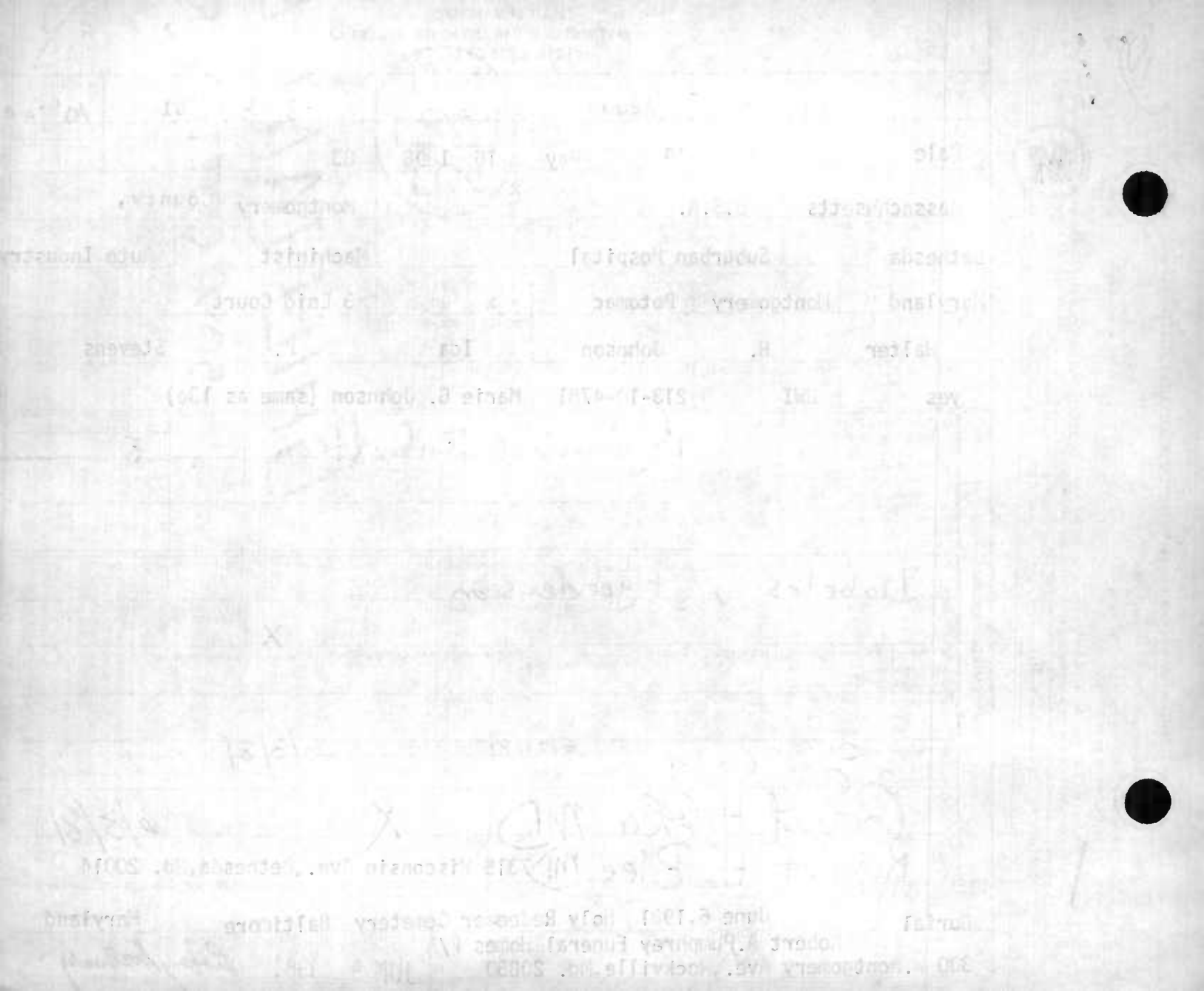
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
HERBERT SHERWOOD JOHNSON			June 3, 1981			10:45 AM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE			7. IF UNDER 1 YEAR		
Male	Caucasian	May 16 1898	83 YRS			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
Massachusetts	U.S.A.		Montgomery County, MD					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Bethesda	Suburban Hospital		Machinist			Auto Industry		
13a. STATE			13b. CITY OR TOWN			13c. STREET ADDRESS		
Maryland			Montgomery			Potomac		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
Walter H. Johnson			Ida P. Stevens					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT		
yes			WWI			213-10-4781		
			Marie G. Johnson (same as 13c)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>								8
4100 DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:								
<u>Diabetes, Hypertension</u>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>5/29/81</u> , 19____, to <u>6/3/81</u> , 19____, that (I) (we) last saw the deceased alive on <u>6/2/81</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (above and) (did) (did not) view the body after death.								
22b. SIGNATURE			DEGREE			22c. DATE SIGNED		
<u>Robert H. Blee MD</u>			<u>MD</u>			<u>6/3/81</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS					
<u>Robert H. Blee MD</u>			<u>7315 Wisconsin Ave., Bethesda, Md. 20014</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY		
Burial			June 6, 1981			Holy Redeemer Cemetery		
						Baltimore		
24. FUNERAL DIRECTOR NAME			24b. ADDRESS			25a. DATE REC'D. BY REGISTRAR		
Robert A. Pumphrey			Funeral Homes P/A			JUN 9 - 1981		
300 W. Montgomery Ave., Rockville, Md. 20850						25b. REGISTRAR'S SIGNATURE		
						<u>Patricia McBrady</u>		



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

M

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										7 1 1 6 3 2 4	
1. FOR STATE REGISTRAR					CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR	
FIRST MIDDLE LAST Hosea B Johnson					MONTH DAY YEAR 6-18-81					1:50 PM	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		
Male		White		MONTH DAY YEAR 12-30-05			75 YRS		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Illinois		U.S.A.				Montgomery MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring		Holy Cross Hospital				Purchasing Agent		Gov. Services			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS				
13a. STATE COUNTY CITY OR TOWN Maryland Montgomery Silver Spring					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3417 Kilkenny Street				
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
James Reed Johnson					Mary Eunice Ballard						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
Yes WW II					307-03-3679		Evelyn E. Johnson/ Wife/Silver Spring, Md. 3417 Kilkenny St.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4140 } DUE TO, OR AS A CONSEQUENCE OF (b) Acute coronary insufficiency										Immed.	
} DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic heart disease										Undet.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Left cerebral Thrombosis, Right ureteral calculus.											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
N/A			N/A			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			N/A YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
N/A											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from 5/3/81 to 6/18/81, that (I) (we) last saw the deceased alive on 6/18/81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE William F. Simpson, MD					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED 6/18/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William F. Simpson, MD					22e. ADDRESS 8106 N. H. Ave. Silver Spring Md 20903						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE			
Cremation			June 21, 1981		Lee's Crematory			Washington, D.C.			
24. FUNERAL DIRECTOR NAME ADDRESS Hines/Rinaldi F.H./ Silver Spring, Md. 20904					25a. DATE REC'D. BY REGISTRAR JUN 24 1981			25b. REGISTRAR'S SIGNATURE			



*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "H. Johnson" and "Silver Lake" are faintly visible.]*

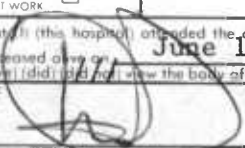

THE UNIVERSITY OF CHICAGO  
SILVER LAKE, ILL. 60461  
JAN 1964

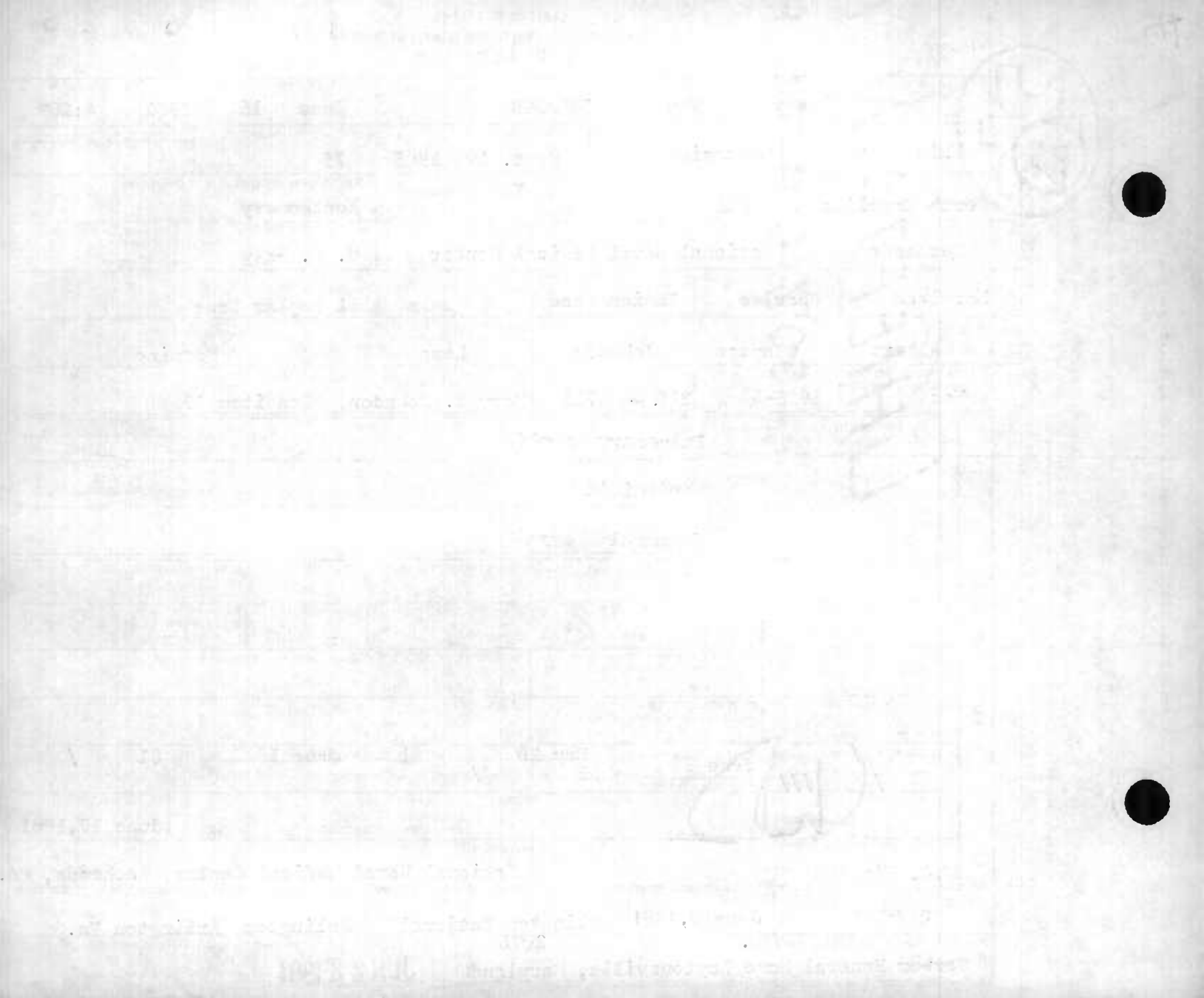
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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					8 1 1 6 3 2 5				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
FIRST MIDDLE LAST Kinsey Ray JOHNSON					MONTH DAY YEAR June 16 1981				
3. SEX Male					4. RACE Caucasian				
5. DATE OF BIRTH					6. AGE (IN YEARS LAST BIRTHDAY)				
MONTH DAY YEAR Sept. 29 1905					75 YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)					7b. CITIZEN OF WHAT COUNTRY?				
North Carolina					USA				
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH				
10. CITY OR TOWN OF DEATH Bethesda					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center				
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U. S. Navy					12b. KIND OF BUSINESS OR INDUSTRY Navy				
13a. STATE Maryland					13b. CITY OR TOWN Indian Head				
13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13d. STREET ADDRESS 11 Poplar Lane				
14. FATHER'S NAME FIRST MIDDLE LAST Albert Clayton Johnson					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lena Manning				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes					16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 1928-48				
17. INFORMANT Mary B. Johnson, See item 13					ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> 3240 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Meningitis</u> (c) <u>Cerebral Abscess</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>May 26</u> 19 <u>81</u> , to <u>June 16</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>June 16</u> 19 <u>81</u> , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) see the body after death.									
22b. SIGNATURE 					22c. DATE SIGNED June 17, 1981				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M.J. Higgins MD					22e. ADDRESS National Naval Medical Center, Bethesda, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL					23b. DATE June 19, 1981				
23c. NAME OF CEMETERY OR CREMATORY Arlington National					23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Arlington Va.				
24. FUNERAL DIRECTOR FRANCIS H. 20760 NAME ADDRESS Barber Funeral Home Laytonsville, Maryland					25a. DATE REC'D. BY REGISTRAR JUN 22 1981				
25b. REGISTRAR'S SIGNATURE 									



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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 6 3 2 6			
1 - FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Leonard Johnson</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>June 5, 1981</b>		2b. HOUR <b>7:30A M</b>	
3. SEX <b>Male</b>		4. RACE <b>Cau.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 10 1899</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Minnesota</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>12516 O'Fallon Street</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Farmer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
13a. STATE <b>Wisconsin</b>		13b. COUNTY <b>Polk</b>		13c. CITY OR TOWN <b>Frederic</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Louis Johnson</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Marie Evensen</b>		13e. STREET ADDRESS <b>Rt. 2 Box 142 54837</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>399-36-7451</b>		17. INFORMANT ADDRESS <b>Helga M. Johnson Same as 13e.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>A &amp; C carcinoma of Prostate</b> <b>1850</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 yrs</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>4/130</b> , 19 <b>81</b> , to <b>6/5</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>4/130</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Edward H. Scow, M.D.</b>				DEGREE <b>ATTENDING PHYSICIAN</b> MEDICAL <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>6/5/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>EDWARD H. LEVIN</b>				22e. ADDRESS <b>8630 FENTON ST.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>June 9.81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Zion Lutheran Church Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Frederic Polk Wis.</b>	
24. FUNERAL DIRECTOR <b>Black Laurel Funeral Home, Inc.</b>				25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>JUN 8 - 1981</b>			
26. ADDRESS <b>7601 Sandy Spring Rd. Laurel, Md. 20810</b>							

BP \_\_\_\_\_



BRITISH AMERICAN

FOR COTTON 1880



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post-mortem may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of age.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 1 1 6 3 2 7	
1 - FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Raymond L Johnson</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>6 2 81</b>			2b. HOUR <b>11:01 AM</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 11 1893</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD					
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NO IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Meat Cutter</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Family Market</b>		
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spr.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>603 Sligo Ave # 511</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Henry Johnson</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Delilah Robinson</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>----- 578-01-7998</b>		17. INFORMANT (wife) ADDRESS <b>Gertrude A. Johnson-(same as 13e)</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>4100</b> (b) <b>CORONARY ATHEROSCLEROSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>18 HRS</b> <b>10 YEARS</b>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (the hospital) attended the deceased from <b>19 76</b> to <b>JUNE 2</b> 19 <b>81</b> , that (I) (we) lost the deceased alive on <b>JUNE 2</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Edward A. Beeman</b> MD					DEGREE <b>MD</b>			22c. DATE SIGNED <b>JUNE 2, 1981</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>EDWARD A. BEEMAN M.D.</b>					22e. ADDRESS <b>8830 CAMERON ST. SILVER SPRING MD 20910</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>6-5-1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Sil. Spring Montgomery Md</b>			
24. FUNERAL HOME OR OTHER PERSON TO WHOM REMAINS WERE DELIVERED <b>Warner E. Pumphrey, Inc. 8434 Ga. Ave., S.S. Md.</b>					25a. DATE REC'D. BY REGISTRAR <b>JUN 9 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Christy E. Wilson</b>				



2014

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMM - 16 50M 1/81  
(VRA 15, 4)19  
FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1

1 6 3 2 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>BETTE S JONES</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6 23 81</b>		2b. HOUR <b>1256A</b>
3. SEX <b>FEMALE</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>9-30-23</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>57</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Missouri</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.		
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>ACCOUNTING CLERK</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>MONTGOMERY</b>	13c. CITY OR TOWN <b>SILVER SPRING</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>1905 DENNIS AVENUE</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>UNKNOWN</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>AUDREY SWAN</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>098-12-7423</b>	17. INFORMANT <b>DAUGHTER</b> <b>DONNA MILLER</b> ADDRESS <b>2425 ECCLESTON ST SILVER SPRING, MD.</b>		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure</b> <b>5163</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Alcohol</b> (c) <b>Serratomyositis</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>Depress</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (he) (this hospital) attended the deceased from <b>4-76</b> , 19 <b>81</b> , to <b>2 June</b> , 19 <b>81</b> , that (he) (we) lost saw the deceased alive on <b>23 June</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Norman S. Koval</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>6-23-81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Norman S. Koval</b>		22e. ADDRESS <b>8750 Georgia Ave S-S MD 20910</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>6/25/81</b>	23c. NAME OF CEMETERY OR CREMATORY <b>PARKLAWN CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>ROCKVILLE MONT MD.</b>	
24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 30 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Jeffrey H. Brady</b>	
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901					

MEDICAL CERTIFICATION

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1922-1-1

1922-1-1



1922-1-1

1922-1-1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

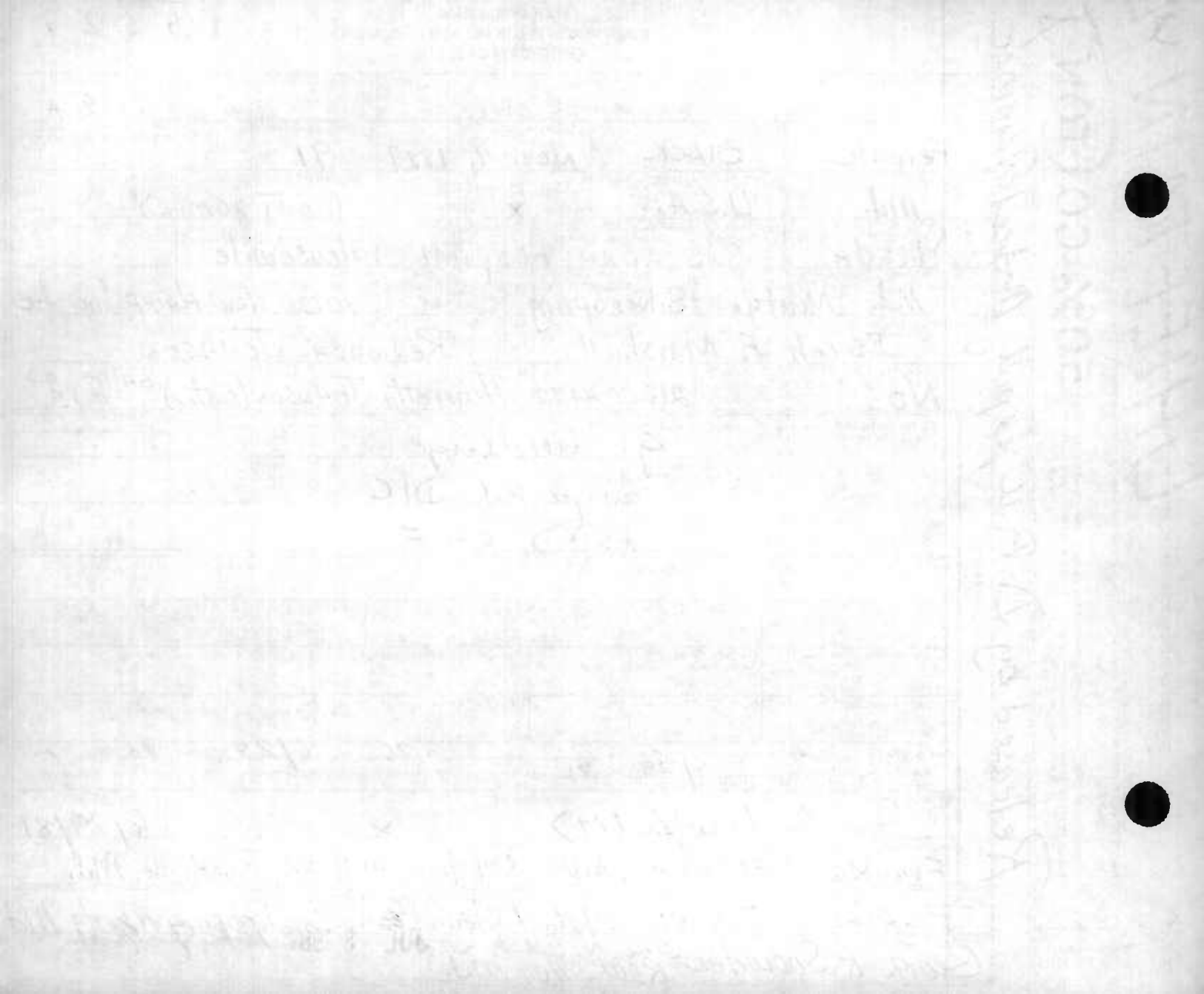
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial/cremation permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene after to burial/cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

Released by Dr. Bill Deputy Medical Examiner

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
CERTIFICATE OF DEATH										
FOR 1. STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE E. LAST JONES					2a. DATE OF DEATH MONTH DAY YEAR 6 29 81			2b. HOUR 8 A M		
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Nov. 7, 1889		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.					13b. CITY OR TOWN Silver Spring		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 10120 New Hampshire Ave	
14. FATHER'S NAME FIRST ISIAH MIDDLE F. LAST MARSHALL					15. MOTHER'S MAIDEN NAME FIRST REBECCA MIDDLE JOHNSON LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-30-4472		17. INFORMANT ADDRESS Henrietta JOHNSON (sister) SAME AS #13						
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140 91 bleeding DUE TO, OR AS A CONSEQUENCE OF (b) suspected DIC DUE TO, OR AS A CONSEQUENCE OF (c) ACHD, CHF										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 6/29/81 to 6/29/81, that (I) (we) last saw the deceased alive on 6/29/81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Frankie Westphal MD					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/29/81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frankie WESTPHAL, MD.					22e. ADDRESS 809 Veirs Mill Rd, Rockville, Md.					
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) BURIAL			23b. DATE 7-2-81		23c. NAME OF CEMETERY OR CREMATOR Mutual Mem. Cem.		23d. LOCATION Sandy Spring Md.			
24. FUNERAL DIRECTOR NAME George R. Snowden 246 N. Wash. St. Rockville, Md.										





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 6 3 3 0			
1- FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
1st MARY 2nd Marie 3rd Karlsvan				June 6 1981 7:30 AM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE	
Female		WHITE		10 10 23		57 YRS.	
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
U.S.A. Alabama		U.S.		Montgomery		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK, BUSINESS, OR INDUSTRY)		12b. KIND OF BUSINESS OR INDUSTRY	
Takoma Park		Washington Adventist Hosp.		housewife		home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS?			
13b. STATE 13c. COUNTY 13c. CITY OR TOWN				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Md. Montgomery Takoma Park				13e. STREET ADDRESS			
				7051 Carroll Ave.			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
1st OSCAR 2nd F 3rd Goggans				1st Carlie 2nd M. 3rd Bernette			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
yes				WW II		Paul R. Karlsvan PO Box 457 College Park Md. 20740	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:				15 days			
IMMEDIATE CAUSE (a) 4912 Pneumonia				DUE TO, OR AS A CONSEQUENCE OF			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:				(b) Emphysema 15 yrs			
				(c) Chronic Bronchitis 25 yrs			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from 5/21, 1981, to 6/6, 1981, that (I) (we) lost saw the deceased alive on 6/5, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Alfred Munzer M.D.		DEGREE M.D.		22c. DATE SIGNED 6/6/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
Alfred Munzer M.D.				7600 Carroll Avenue Takoma Park Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		6/10/81		Sarasota Memorial Park		Sarasota, Florida	
24. FUNERAL DIRECTOR NAME				15. DATE RECEIVED BY REGISTRAR			
Tyson Wheeler Funeral Home, Inc.				JUN 10 1981			
1331 Rockville Pike Rockville, Maryland				REGISTRAR'S SIGNATURE			

1/1/71

WHITE

10 10 23 27

Alaska

Housewife home

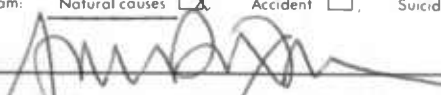
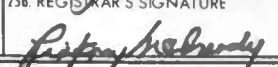
Yes W II 553-16 4508 Paul H. Karlander PO Box 152 College Park Md. 20740

Burial 6/10/81 Sarasota Memorial Park Sarasota, Florida  
Tyson Wheeler Funeral Home, Inc.  
1331 Rockville Pike Rockville, Maryland

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST Norma		MIDDLE Theresa		LAST Keating		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR		2b. HOUR M	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH (MONTH DAY YEAR) June 3, 1943		6. AGE (IN YEARS) (LAST BIRTHDAY) 38 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD 6 23 1981		2d. HOUR P M 5:30	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) JAMAICA		7b. CITIZEN OF WHAT COUNTRY? JAMAICA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.							
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 73 E. Wayne Avenue		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Secty		12b. KIND OF BUSINESS OR INDUSTRY Embassy							
13a. STATE Md		13b. COUNTY Monty		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 73 E. Wayne Ave					
14. FATHER'S NAME FIRST George		MIDDLE mya		LAST Keating		15. MOTHER'S MAIDEN NAME FIRST ENA		MIDDLE N/A		LAST Sengert			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None		17. INFORMANT Mary Keating, Kingston		ADDRESS 2304 R Lown							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute intracerebral hemorrhage</u> 4310 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE 				M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 6/24/81					
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St. Balto., MD.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE July 4, 1981				23c. NAME OF CEMETERY OR CREMATORY Calvary					
23d. LOCATION CITY OR TOWN Kingston				COUNTY Dorchester				STATE MD					
24. FUNERAL DIRECTOR NAME W.W. Chambers				ADDRESS 5605 GA Ave S.I. Sping mcl				25a. DATE REC'D. BY REGISTRAR JUN 26 1981					
25b. REGISTRAR'S SIGNATURE 													

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 1 1 6 3 3 2			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>FREDERICK I KEISTER</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>JUNE 7 1981</b>		2b. HOUR <b>6:05 PM</b>	
3. SEX <b>MALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>02 25 1890</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Connecticut</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD.</b>	
10. CITY OR TOWN OF DEATH <b>Wheaton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MANOR CARE Wheaton</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RR Crossing</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>RAILROAD</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Kensington</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>FREDERICK E KEISTER</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MINNIE THOMAS</b>		13e. STREET ADDRESS <b>3413 Nimitz Road</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>UNKNOWN</b>		16b. SOCIAL SECURITY NO. <b>706-01-4615</b>		17. INFORMANT ADDRESS <b>MARGARET Peterson Same as #13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>4140 ACUTE CONGESTIVE HEART FAILURE</b> IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 HR</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) <del>personally</del> attended the deceased from <b>MAY 27, 1981</b> to <b>JUNE 7, 1981</b> , that (I) <del>was</del> last saw the deceased alive on <b>JUNE 4, 1981</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> (did) <del>not</del> view the body after death.							
22b. SIGNATURE <b>Walter E. Gooch MD</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>June 8/</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WALTER E. GOOCH MD</b>				22e. ADDRESS <b>2309 SHORDEFIELD RD WHEATON MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal-Burial</b>		23b. DATE <b>6/9/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mayflower Hill Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Taunton, Mass.</b>	
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b> NAME <b>5130 Wisc. Ave. N.W. Wash., D.C.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 10 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Barry McHenry</b>	

BP

Field No. 1001 Date June 1, 1901

Locality (Altitude) 2000 ft.

Plant Name X

Number of specimens 1

Number of flowers 1

Number of fruits 1

Number of seeds 1

Number of leaves 1

Number of stems 1

Number of roots 1

Number of branches 1

Number of flowers 1

Number of fruits 1

Number of seeds 1

Number of leaves 1

Number of stems 1

Number of roots 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				7a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>FRANK Carl Kelle</b>				7b. HOUR <b>6 20 P M</b>			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4 30 09</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>72</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY MD</b>	
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>POTOMAC VALLEY Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Wholesale meat</b>	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Bethesda</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John F. Kelle</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Helene M. Schultz</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>578-07-0884</b>		17. INFORMANT ADDRESS <b>19322 Dunbridge Way Gaithersburg, Md. 20760</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>1509 IMMEDIATE CAUSE (a) Carcinoma of Esophagus</b> DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>6 mos.</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Emphysema</b>							
19a. DATE OF OPERATION <b>May 1981</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>feeding gastrostomy</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>we</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (he/she/it) attended the deceased from <b>April</b> , 19 <b>81</b> , to <b>June 5</b> , 19 <b>81</b> , that (1) <del>was</del> most saw the deceased alive on <b>June 5</b> , 19 <b>81</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (1) <del>did</del> (did not) view the body after death.							
22b. SIGNATURE <b>James W. Egan M.D.</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>6.5.81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JAMES W. EGAN M.D.</b>				22e. ADDRESS <b>5413 Cedar Lane #206-C Bethesda, Maryland 20014</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/8/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood Prince George Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Tyson Wheeler Funeral Home</b>				25. DIRECTOR BY REGISTRAR (TYPE OR PRINT) <b>6001 BP</b>			
1331 Rockville Pike, Rockville, Md. 20852							



1231 Rockville Pike, Rockville, Md. 20852  
Tyson Wheeler Funeral Home

Burial 6/2/81 Ft. Lincoln Greenwood Prince Georges Co.

5413 Cedar Lane 206-c Rockville, 20854

No ----- 578-07-0884 Carl J. Kelle Baltimore, Md. 10160

John T. Kelle Helene M. Bernita

Maryland Montgomery Bethesda x 10250 Westlake Drive

Retired

Washington, D.C. U.S.A.

Carl

FOR  
1- STATE  
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		ESTIMATED		MONTH		DAY		YEAR		2b. HOUR					
John Raymond Keppler								6/15/1981		7A													
1. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR			
Male		White		May 30, 1904		77 YRS.						6/15/1981		7A									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH											
Maryland				U.S.A.								Montgomery MD.											
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
Bethesda				8500 River Road								Ret-Sales Manager				Westinghouse Corp.							
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS							
Maryland				Montgomery				Bethesda				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				8500 River Road							
14. FATHER'S NAME								15. MOTHER'S MAIDEN NAME															
FIRST MIDDLE LAST								FIRST MIDDLE LAST															
William -- Keppler								Belledena -- Nolte															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)								16b. SOCIAL SECURITY NO.								17. INFORMANT ADDRESS							
Yes								WW II								Thomas Gittings, 806 - 15th St., NW, Wash., DC							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																							
PART 1 DEATH WAS CAUSED BY:																							
IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u>																							
DUE TO, OR AS A CONSEQUENCE OF																							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.																							
(b) DUE TO, OR AS A CONSEQUENCE OF																							
(c)																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																							
19a. DATE OF OPERATION								19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?							
																YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH								21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
								P.M. 19															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>								21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION											
												CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE <u>John S. Ball</u>								TITLE (SPECIFY) <u>Deputy</u> MEDICAL EXAMINER								DATE SIGNED <u>6/15/81</u>							
EXAMINER'S NAME (TYPE OR PRINT) <u>John G. Ball</u>								ADDRESS <u>Bethesda, Montgomery Co., Maryland</u>															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)								23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION							
Cremation								6/16/81				Cedar Hill Crematory				Suitland, Maryland							
24. FUNERAL DIRECTOR NAME <u>Joseph Gawler's Sons, Inc.</u>								ADDRESS <u>5130 Wisconsin Ave., NW, Wash., D.C. 20016</u>				25a. DATE REC'D. BY REGISTRAR <u>JUN 18 1981</u>				25b. REGISTRAR'S SIGNATURE <u>Henry McBrady</u>							

MEDICAL CERTIFICATION

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Claude W. Keyes</b>		2a. DATE OF DEATH MONTH <b>6</b> DAY <b>25</b> YEAR <b>81</b>		2b. HOUR <b>5:10 PM</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>9</b> DAY <b>12</b> YEAR <b>1907</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Bethesda</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. Bus driver</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Transit</b>
13a. COUNTY <b>Montgomery</b>		13b. CITY OR TOWN <b>Chevy Chase</b>		13c. STREET ADDRESS <b>4740 Bradley Blvd</b>	
14. FATHER'S NAME FIRST <b>Unknown</b> MIDDLE <b>Phillip</b> LAST <b>Keyes</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Unknown</b> MIDDLE <b>Molly</b> LAST <b>Cornell</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>	
16b. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT <b>Marie C. Musgrove</b>		ADDRESS <b>2105 Arcola Ave Silver Spring Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Respiratory Failure</b> <b>4960</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Severe Chronic Obstructive Pulmonary Disease</b> (Two) <b>2 years</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Pneumonia</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION <b>—</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>—</b>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>—</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>—</b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>June 22, 1981</b> to <b>June 25, 1981</b> , that (I) (we) lost saw the deceased alive on <b>June 25, 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>James A. Rossi MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>6-26-81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JAMES A. ROSSI MD</b>		22e. ADDRESS <b>611 EXECUTIVE BLVD. ROCKVILLE, MARYLAND 20852</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6-29-1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Chestnut Grove</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Herndon Va.</b>		24. FUNERAL DIRECTOR NAME <b>Warner E. Pumphrey Inc. Howard &amp; Hale</b> ADDRESS <b>8434 Georgia Ave Silver Spring Md.</b>			
25a. DATE REC'D. BY REGISTRAR <b>JUN 30 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Robert M. ...</b>			

*[Faint, mostly illegible handwritten text on lined paper. The text appears to be a list or series of entries, possibly related to a library or archival collection. Some words like "LIBRARY" and "DATE" are faintly visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Department of Health and Mental Hygiene, and page 3 should be filed with the local health department. If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Released by John Bell, Deputy M.E.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE											
CERTIFICATE OF DEATH											
REG. NO.											
1. DECEASED NAME (TYPE OR PRINT) <b>TU (NMN) KIM</b>					2a. DATE OF DEATH		MONTH <b>6</b>	DAY <b>28</b>	YEAR <b>81</b>	2b. HOUR <b>8:52</b> PM	
3. SEX <b>Male</b>		4. RACE <b>ORIENTAL</b>		5. DATE OF BIRTH MONTH <b>9</b> DAY <b>21</b> YEAR <b>38</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>42</b> YRS		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>CAMBODIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY MD.</b>					
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SUBURBAN Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Bus Driver</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Cty Gov't.</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>Maryland</b> COUNTY <b>Montgomery</b>					13c. CITY OR TOWN <b>Wheaton</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>12508 Conn. Avenue</b>		
14. FATHER'S NAME FIRST <b>Unknown</b> MIDDLE <b></b> LAST <b></b>					15. MOTHER'S MAIDEN NAME FIRST <b>Unknown</b> MIDDLE <b></b> LAST <b></b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Bro-in-law</b> ADDRESS <b>TAN LONG, 12508 Conn. Ave Wheaton Md 20904</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: <b>0703</b> IMMEDIATE CAUSE (a) <b>Hepatic failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cirrhosis + Hepatoma</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hepatitis B, chronic</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>7 years</b> <b>7 years</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 mos</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>6/21</b> , 19 <b>81</b> , to <b>6/21</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>6/21</b> , 19 <b>81</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (we) view the body after death.											
22b. SIGNATURE <b>R. Lindeman MD</b> DEGREE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>June 21/81</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROBERT LINDEMAN, M.D.</b>						22e. ADDRESS <b>10215 Verwood Dr. Bethesda, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>June 6, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>PG City MD.</b>			
24. FUNERAL DIRECTOR NAME <b>W.W. Chambers Co. 8653 GA. AVE S.S., Md 20910</b>						25a. DATE REC'D. BY REGISTRAR <b>JUN 9 1981</b>			25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

(200)

10-015-1005

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Ward and Wainwright, 1962

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 84

2004

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ALBERT HINDZMAN



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

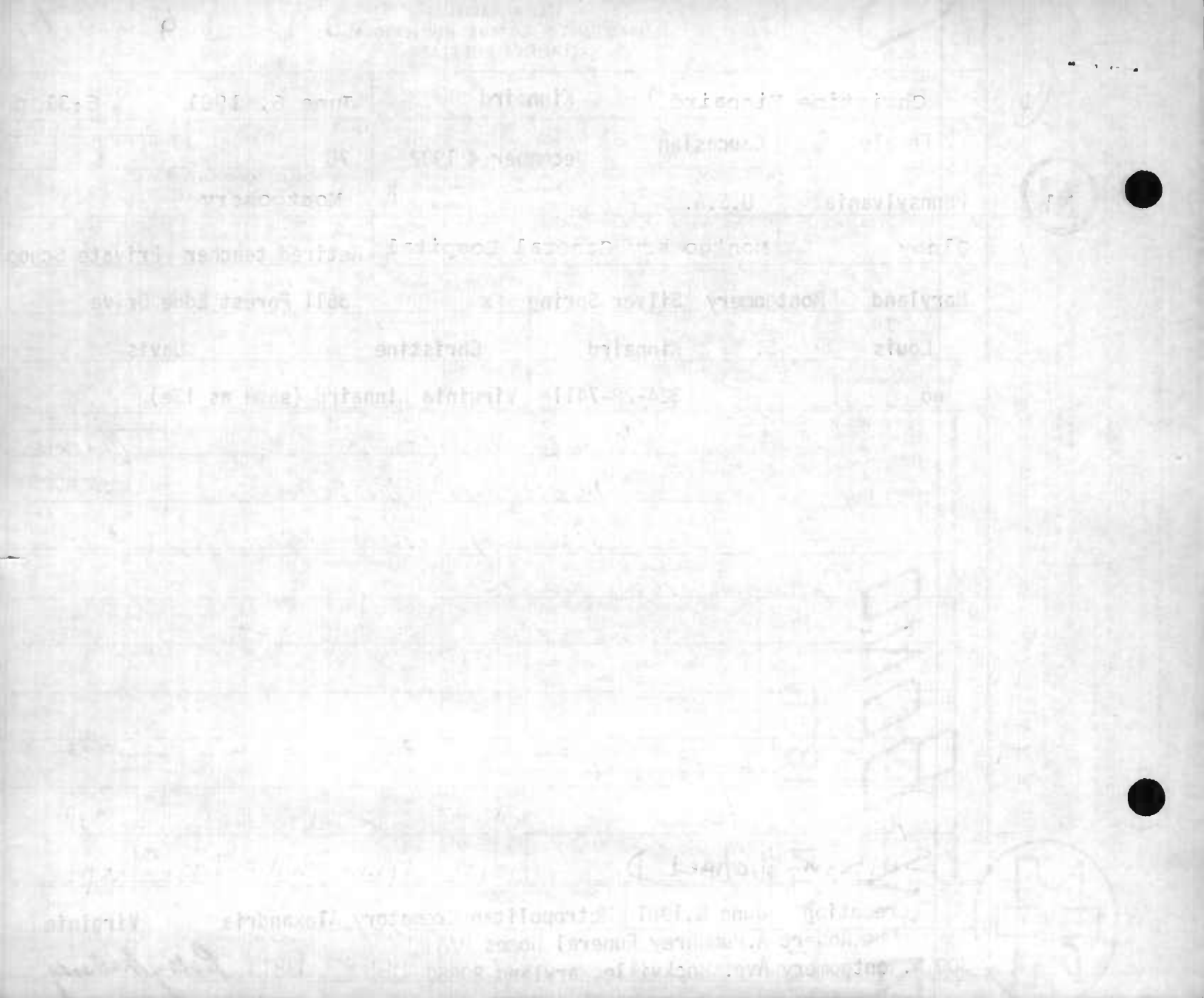
|  |  |   |   |   |  |  |  |  |  |
|--|--|---|---|---|--|--|--|--|--|
| DECEASED NAME<br>(TYPE OR PRINT)<br><b>Christine (NMN) Kinnaird</b>  |  |   | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>June 6, 1981</b> |   |  | 2b HOUR<br><b>6:31 PM</b>  |  |  |  |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>Caucasian</b>  |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>December 4 1902</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>        |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                   |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Olney</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Montgomery General Hospital</b> |   |   |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired teacher</b>      |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Private School</b>  |  |
| 13a STATE<br><b>Maryland</b>   |  | 13b COUNTY<br><b>Montgomery</b>   |   | 13c CITY OR TOWN<br><b>Silver Spring</b>  |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e STREET ADDRESS<br><b>3511 Forest Edge Drive</b>  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Louis S. Kinnaird</b>  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Christine Davis</b>  |   |   |  |  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>   |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>324-28-7411</b>  |   | 17 INFORMANT ADDRESS<br><b>Virginia Kinnaird (same as 13e)</b>  |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Coronary Artery Disease</b> |  |   |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>12 hours</b><br><b>10 hours</b><br><b>2 years</b>                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d)<br><b>Carcinoma colon rectum</b>   |  |   |   |   |  |  |  |  |  |
| 19a DATE OF OPERATION<br><b>6-4-81</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Carcinoma colon</b>  |   |   |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>PM 19</b>  |   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22a I certify that (this hospital) attended the deceased from <b>6-1-81</b> 19 <b>81</b> to <b>6-6-81</b> 19 <b>81</b> , that (we) lost<br>saw the deceased alive on <b>6-5-81</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) did (did not) view the body after death.  |  |   |   |   |  |  |  |  |  |
| 22b SIGNATURE<br><b>Michael D. Sulkin</b>  |  |   |   | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |  | 22c DATE SIGNED<br><b>6-7-81</b>   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Sulkin, Michael D.</b>  |  |   |   | 22e ADDRESS<br><b>18101 Prince Phillip Dr, Olney</b>  |  |  |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>   |  | 23b DATE<br><b>June 8, 1981</b>   |   | 23c NAME OF CEMETERY OR CREMATORY<br><b>Metropolitan Crematory Alexandria</b>   |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Virginia</b>                                   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Robert A. Pumphrey, Funeral Homes P/A<br/>300 W. Montgomery Ave., Rockville, Maryland 20850</b>   |  |   |   | 25a DATE REC'D. BY REGISTRAR<br><b>JUN 11 1981</b>  |  | 25b REGISTRAR'S SIGNATURE<br><b>R. J. H. H. H.</b>   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP



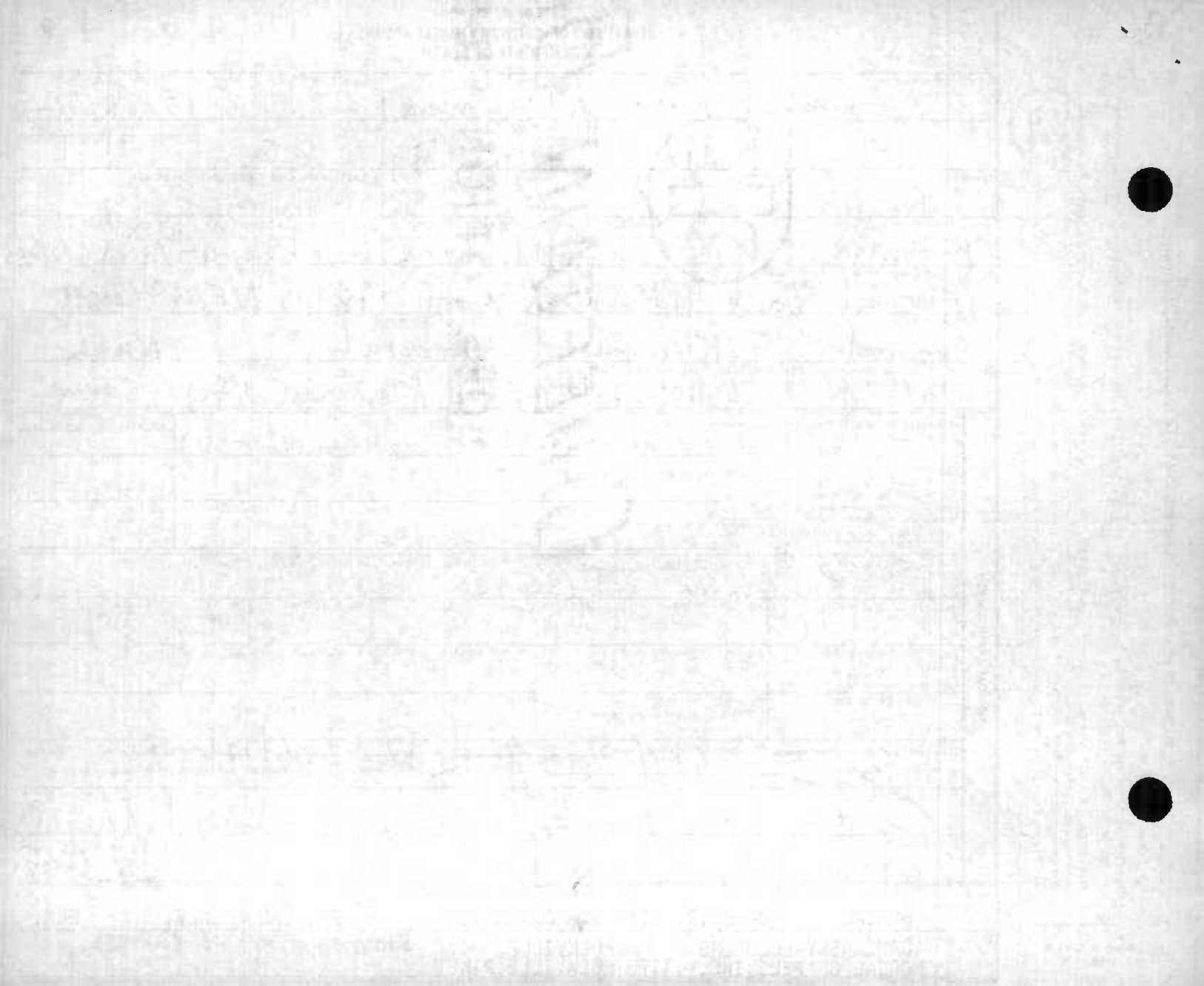
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 8 1 1 6 3 3 8   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  | CERTIFICATE OF DEATH  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |   |  | 7a. DATE OF DEATH   |  |  |  |
| FIRST MIDDLE LAST<br>Samuel Mayer Kleinman   |  |   |  | MONTH DAY YEAR<br>6 17 81   |  | 2b. HOUR<br>10 <sup>30</sup> A M   |  |
| 3. SEX<br>M  |  | 4. RACE<br>W  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 12 99   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Russia  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Potomac   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>8314 Snug Hill Lane |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Store keeper  |  |
| 13a. STATE<br>Florida  |  | 13b. COUNTY<br>Dade   |  | 13c. CITY OR TOWN<br>N. Miami Beach   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Bernard Kleinman   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Deborah Nuch   |  | 16. SOCIAL SECURITY NO.<br>101-07-9769  |  |  |  |
| 17. INFORMANT<br>ADDRESS<br>Ethel Kleinman (wife)  |  | 18. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  | 19. IF YES, GIVE WAR OR DATES   |  | 20. SAME   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cerebrovascular arterio sclerosis<br>4370<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>Parkinson's Disease   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/16/81 to 6/17/81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Bertram Weisbaum   |  |   |  | DEGREE<br>MD  |  | 22c. DATE SIGNED<br>6/17/81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Bertram Weisbaum  |  |   |  | 22e. ADDRESS<br>6490 Landover Rd. Landover Park Md 20785  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b. DATE<br>JUNE 19, 81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>SHARON GARDEN   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>FT. LAUDERDALE, FLA.   |  |
| 24. FUNERAL DIRECTOR<br>NAME DANZANSKY-GOLDBERG<br>ADDRESS ROCKVILLE, MD.<br>MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE  |  |   |  | 25a. DATE RECD. BY REGISTRAR<br>JUN 20 1981   |  |  |  |
| 25b. REGISTRAR'S SIGNATURE   |  |   |  |   |  |  |  |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH: 16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |   |   |   |   |  |   |  |   |  |
|---|--|---|---|---|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>John O. Koch</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>June 18, 1981</b>                         |   | 2b. HOUR<br><b>6:00 P<sub>M</sub></b>                               |  |   |  |   |  |
| 3 SEX<br><b>Male</b>  |  | 4. RACE<br><b>Caucasian</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan. 30, 1931</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>50</b> YRS.                                    |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County, MD.</b>                |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rockville</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1110 Pipestem Place</b> |   |   |   | 12a. USUAL OCCUPATION<br>(IF MOST OF WORKING LIFE)<br><b>Vice-President</b>          |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>C &amp; P Telephone Co.</b>  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  |   | 13b. COUNTY<br><b>Montgomery</b>  |   | 13c. CITY OR TOWN<br><b>Rockville</b>                               |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1110 Pipestem Place</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Oscar Koch</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Byrne</b>                  |   |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>Korea 215-28-3951</b> |   | 17. INFORMANT<br>ADDRESS<br><b>Cynthia Koch, Same as 13</b>         |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>1890</b> IMMEDIATE CAUSE (a) <b>Metastatic Renal Cell Carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH     |  |   |   |   |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |   |   |   |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                    |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                          |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)              |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |  |   |  |
| 22a. I certify that (I) <input checked="" type="checkbox"/> attended the deceased from <b>Aug. 12, 1980</b> to <b>June 18, 1981</b> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <b>June 6, 1981</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (did not) view the body after death. |  |   |   |   |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Patrick J. Byrne MD</b> DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>   |  |   |   |   |   | 22c. DATE SIGNED<br><b>June 19, 1981</b>   |   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Patrick J. Byrne, M. D.</b>   |  |   |   |   |   | 22e. ADDRESS<br><b>3800 Reservoir Road, N. W.<br/>Washington, D. C.</b>              |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  |  |   | 23b. DATE<br><b>June 20, 1981</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Metropolitan Crematory</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Alexandria, Virginia</b>                       |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>ROBERT A. PUMPHREY FUNERAL HOMES, P. A., Rockville, Maryland</b>   |  |   |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 24 1981</b>                                  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Patricia K. Byrne</b>   |   |  |

MEDICAL CERTIFICATION

29

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100-2





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M7/77  
(VRA 15 (4))

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |   |  |  |  |  |  |
|--|--|---|--|---|--|--|--|--|--|
| CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |  |  |
| REG. NO. 8116340   |  |   |  |   |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Florence E (NAM) Koenig</b>   |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6 29 81</b>  |  | 2b. HOUR<br><b>9:10 A.M.</b>   |  |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 24 1981</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery MD.</b>  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Rockville</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Hebrew Home of Greater Washington</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>At Home</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |  |  |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Montgomery</b>  |  | 13c. CITY OR TOWN<br><b>Rockville</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>6121 Montrose Avenue</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Fox</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Pauline Fox Unknown</b>   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>None</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Edward Koenig-Son - Bethesda Md. 20014</b>   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Septicemia</b><br><b>4210</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>SRE</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>-</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/2/1970</b> , 19 <b>70</b> , to <b>6/29/1981</b> , that (I) (we) last saw the deceased alive on <b>6/29/81</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.      |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>M.D. King</b>   |  |   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>6/29/81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>H.D. KHI ANE Y</b>   |  |   |  | 22e. ADDRESS<br><b>Hebrew Home of Greater Washington</b>  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>July 1, 1981</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King David Mem. Gardens</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Falls Church, Virginia</b>  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>W. W. Chambers Co. 8655 6a Ave. SS, Md. 20910</b>   |  |   |  |   |  |  |  |  |  |
| 25a. DATE RECEIVED BY REGISTRAR<br><b>JUL 6 1981</b>   |  |   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |  |  |

MEDICAL CERTIFICATION

29

1

BP





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 6 3 4 1

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |   |   |
|--|--|--|--|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>MILTON L. KUDER                     |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>6/29/81                 |   | 2b. HOUR<br>2:30 AM   |   |
| 3 SEX<br>Male  | 4 RACE<br>CAUC.                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>January 30, 1909   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 74 HRS.<br>HOURS MIN.                                |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A. | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY MD.                                |   |   |
| 10. CITY OR TOWN OF DEATH<br>ROCKVILLE                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>SHADY GROVE ADVENTIST   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Res. & Dev. Engr. |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>U.S. Govt. |
| 13a. STATE<br>Maryland   |  |  | 13b. COUNTY<br>Montgomery                                      | 13c. CITY OR TOWN<br>Gaithersburg   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George Kuder                     |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Amelia Ebisch |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no |  | 16b. SOCIAL SECURITY NO.<br>208-03-0842  |  | 17. INFORMANT<br>ADDRESS<br>Matilda L. Kuder (same as 13e)                            |   |   |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

4100

IMMEDIATE CAUSE (a)

CARDIOGENIC SHOCK

DUE TO, OR AS A CONSEQUENCE OF

(b)

ACUTE MYOCARDIAL INFARCTION

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

HYPERTENSION, LABILE DIABETES

|  |  |  |  |  |   |                             |
|--|--|--|--|--|---|-----------------------------|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                             |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |                             |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |                             |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/29/81 to 6/29/81, that (I) (we) lost<br>saw the deceased alive on 6/29/81, and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |                             |
| 22b. SIGNATURE<br>Roger Stevenson MD   |  | DEGREE<br>MD   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>6/29/81 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ROGER STEVENSON, JR, MD   |  | 22e. ADDRESS<br>11125 ROCKVILLE PIKE, ROCKVILLE, MD                    |  |  |   |                             |

|   |                            |  |  |
|---|----------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation | 23b. DATE<br>June 30, 1981 | 23c. NAME OF CEMETERY OR CREMATORY<br>Metropolitan Crematory Alexandria Fairfax Virginia | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |
| 24. FUNERAL DIRECTOR Robert A. Pumphrey                   |                            | 25. DATE REC'D. BY REGISTRAR 26. REGISTRAR'S SIGNATURE<br>Jul 9 1981                     |  |
| 300 W. Montgomery Ave., Rockville, Maryland               |                            |  |  |

KLONK, WILLIAM (1901-1981)

WILLIAM KLONK (1901-1981)

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 6 3 4 2

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |                            |  |  |
|---|--|---|--|---|----------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Cornelia (None) LADD</i>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>6-2-81</i> |   | 2b. HOUR<br><i>4:30 AM</i> |  |  |
| 3. SEX<br><i>Female</i>   |  | 4. RACE<br><i>Caucasian</i>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>10 26 23</i>   |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><i>57</i>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>N.Y.</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Montgomery County</i> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Takoma Park, Md.</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Washington Adventist Hosp</i> |  | 12a. USUAL OCCUPATION<br>(TYPE OF BUSINESS OR WORKING LIFE)<br><i>Editorial Management</i>  |                            | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Sierra Club</i>  |  |
| 13a. STATE<br><i>Md.</i>  |  |   |  | 13b. COUNTY<br><i>Montgomery</i>  |                            | 13c. CITY OR TOWN<br><i>Kensington</i>   |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  | 13e. STREET ADDRESS<br><i>10225 Kensington Hwy #303</i>   |                            |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Horner Calver</i>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Hulstigs Rappe</i>  |                            |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>Yes</i>  |  |   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>WW II Unknown</i>   |                            | 17. INFORMANT<br>ADDRESS<br><i>Jeffrey B. Bender/Son/Gaithersburg, Md.</i>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Respiratory Failure</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>breast cancer with lymphangitic spread</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>and metastases to biliary tract</i><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>2 weeks</i><br><i>9 months</i> |  |   |  |   |                            |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |                            |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                            |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                            |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <i>5/14/81</i> , 19____, to <i>6/2/81</i> , 19____, that (1) (we) lost saw the deceased alive on <i>6/1/81</i> , 19____, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.  |  |   |  |   |                            |  |  |
| 22b. SIGNATURE<br><i>Deborah B. Goldberg</i>  |  | DEGREE<br><i>MD.</i>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |                            | 22c. DATE SIGNED<br><i>6/2/81</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>DEBORAH B. GOLDBERG</i>   |  | 22e. ADDRESS<br><i>1106 SPRING ST, SILVER SPRING, MD.</i>   |  |   |                            |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Removal</i>  |  | 23b. DATE<br><i>June 2, 1981</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Uniformed Services University of the Health Sciences</i>   |                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Bethesda, Md.</i>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Capitol Funeral Service, Fairfax, Va.</i>  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>JUN 5 1981</i>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |                            |  |  |

RECEIVED

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 4 FOR YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR<br>1- STATE REGISTRAR  |  |  |  |  |  |  |  |  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH |  |  |  |  |  |  |  |  |  | REG. NO.  |  |                                      |  |                          |  |                  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--------------------------------------|--|--------------------------|--|------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|---------------------|--|--|--|--|--|--|--|--|--|---------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  |  |  |  |  |  |  |  | FIRST MIDDLE LAST  |  |  |  |  |  |  |  |  |  | 2a. DATE KNOWN OF DEATH   |  | 2b. HOUR                             |  |                          |  |                  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |
| DONALD A. LAMBERT  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | MONTH DAY YEAR  |  | MONTH DAY YEAR                       |  |                          |  |                  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |
| 3. SEX   |  |  |  |  |  |  |  |  |  | 4. RACE  |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)                    |  | IF UNDER 1 YR.           |  | IF UNDER 24 HRS. |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |
| Male   |  |  |  |  |  |  |  |  |  | white  |  |  |  |  |  |  |  |  |  | December 28 1916  |  | 64                                   |  | MONTHS DAYS              |  | HOURS MIN.       |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  |  |  |  |  |  |  |  | 8. MARRIED  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  | 2c. DATE PRONOUNCED DEAD |  | 2d. HOUR         |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |
| Washington, D.C.   |  |  |  |  |  |  |  |  |  | U.S.A.   |  |  |  |  |  |  |  |  |  | NEVER MARRIED   |  | MONTGOMERY County MD.                |  | 6 12 81                  |  | 4 05             |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION                           |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |  | 12b. KIND OF BUSINESS OR INDUSTRY    |  |                          |  |                  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |
| Bethesda   |  |  |  |  |  |  |  |  |  | SUBURBAN   |  |  |  |  |  |  |  |  |  | Equipment Specialist  |  | U.S. Govt.                           |  |                          |  |                  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |
| 13a. STATE   |  |  |  |  |  |  |  |  |  | 13b. COUNTY  |  |  |  |  |  |  |  |  |  | 13c. CITY OR TOWN   |  |                                      |  |                          |  |                  |  |  |  | 13d. INSIDE CITY LIMITS?                     |  |  |  |  |  |  |  |  |  | 13e. STREET ADDRESS |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |
| Maryland   |  |  |  |  |  |  |  |  |  | Montgomery   |  |  |  |  |  |  |  |  |  | Rockville   |  |                                      |  |                          |  |                  |  |  |  | YES  |  |  |  |  |  |  |  |  |  | 518 S. Horners Lane |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME  |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |  |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?                                  |  |                                      |  |                          |  |                  |  |  |  | 16b. SOCIAL SECURITY NO.                     |  |  |  |  |  |  |  |  |  | 17. INFORMANT       |  |  |  |  |  |  |  |  |  | ADDRESS       |  |  |  |  |  |  |  |  |  |
| John   |  |  |  |  |  |  |  |  |  | Annie  |  |  |  |  |  |  |  |  |  | yes   |  |                                      |  |                          |  |                  |  |  |  | 218-10-8732                                  |  |  |  |  |  |  |  |  |  | Marian T. Lambert   |  |  |  |  |  |  |  |  |  | (same as 13e) |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |  |  |  |  | PART 1 DEATH WAS CAUSED BY:  |  |  |  |  |  |  |  |  |  | IMMEDIATE CAUSE (a)   |  |                                      |  |                          |  |                  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |
| 8880   |  |  |  |  |  |  |  |  |  | Massive Subdural Hematoma  |  |  |  |  |  |  |  |  |  |   |  |                                      |  |                          |  |                  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |  |  |  |  |  |  |  |  |  | (b)  |  |  |  |  |  |  |  |  |  | with Brain Stem dysfunction   |  |                                      |  |                          |  |                  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  | (c)  |  |  |  |  |  |  |  |  |  | Trauma from Fall  |  |                                      |  |                          |  |                  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)             |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |                                      |  |                          |  |                  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |
| acute alcoholism   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |                                      |  |                          |  |                  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                  |  |  |  |  |  |  |  |  |  | 20. AUTOPSY?  |  |                                      |  |                          |  |                  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | YES   |  |                                      |  |                          |  |                  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH  |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY  |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |                                      |  |                          |  |                  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  | 9 PM. 6-11 1981  |  |  |  |  |  |  |  |  |  | Fall and Head Injury  |  |                                      |  |                          |  |                  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK OR NOT WHILE AT WORK  |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                        |  |  |  |  |  |  |  |  |  | 21f. LOCATION   |  |                                      |  |                          |  |                  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |
| NOT WHILE AT WORK  |  |  |  |  |  |  |  |  |  | ground   |  |  |  |  |  |  |  |  |  | 518 South Horners Ln. Rockville Mont. Md.                                     |  |                                      |  |                          |  |                  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |                                      |  |                          |  |                  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |
| Natural causes, Accident, Suicide, Homicide, Undetermined manner   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |                                      |  |                          |  |                  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE   |  |  |  |  |  |  |  |  |  | TITLE (SPECIFY)  |  |  |  |  |  |  |  |  |  | DATE SIGNED   |  |                                      |  |                          |  |                  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |
| John G. Ball   |  |  |  |  |  |  |  |  |  | M.D. Deputy  |  |  |  |  |  |  |  |  |  | June 12, 1981   |  |                                      |  |                          |  |                  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  |  |  |  |  |  |  |  |  | ADDRESS  |  |  |  |  |  |  |  |  |  |   |  |                                      |  |                          |  |                  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |
| JOHN G. BALL   |  |  |  |  |  |  |  |  |  | 7936 Old Georgetown Rd., Bethesda, Md.   |  |  |  |  |  |  |  |  |  |   |  |                                      |  |                          |  |                  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  |  |  |  |  |  |  |  | 23b. DATE  |  |  |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |                                      |  |                          |  |                  |  |  |  | 23d. LOCATION                                |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |
| Burial   |  |  |  |  |  |  |  |  |  | June 16, 1981  |  |  |  |  |  |  |  |  |  | Parklawn Memorial Park  |  |                                      |  |                          |  |                  |  |  |  | Rockville Montgomery Maryland                |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE  |  |                                      |  |                          |  |                  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |
| Robert A. Pumphrey   |  |  |  |  |  |  |  |  |  | JUN 19 1981  |  |  |  |  |  |  |  |  |  | L. J. Ball  |  |                                      |  |                          |  |                  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |
| NAME   |  |  |  |  |  |  |  |  |  | ADDRESS  |  |  |  |  |  |  |  |  |  |   |  |                                      |  |                          |  |                  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |
| 300 W. Montgomery Ave.   |  |  |  |  |  |  |  |  |  | Rockville, Maryland  |  |  |  |  |  |  |  |  |  |   |  |                                      |  |                          |  |                  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |   |  |
|--|--|---|--|---|--|---|--|--|---|--|
| 1- FOR STATE REGISTRAR   |  |   |  |   | REG. NO.   |   |  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ELIZABETH C. LANAHAN</b>  |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>June 24 1981</b>                           |   |  | 2b. HOUR<br><b>9:32PM</b>  |   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Apr. 28 1900</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS.                                   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN<br>IF UNDER 24 HRS  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Washington D.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                       |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rockville</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Collingswood Nursing Center</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Milliner</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Retail Sales</b>   |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>None</b> 13b. COUNTY <b>None</b> 13c. CITY OR TOWN <b>Wash. D.C.</b> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |   | 13e. STREET ADDRESS<br><b>2141 Eye Street, N.W.</b>                                  |   |  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Edward I. Lanahan</b>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary E. Corkery</b>              |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES) <b>--</b>   |  | 17. INFORMANT <b>Cousin</b> ADDRESS <b>Kensington Md.</b>   |  | 17. INFORMANT <b>Mary B. Zauner</b> ADDRESS <b>5007 Flanders Ave.</b>               |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b><br><b>4349</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CEREBRAL INFARCT</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ARTERIOSCLEROSIS</b> |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 MINUTES</b><br><b>36 HOURS</b><br><b>30 YEARS</b> |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>OCTOBER 80</b> to <b>JUNE 24 81</b> , that (I) (we) last saw the deceased alive on <b>JUNE 24 81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |  |   |  |
| 22b. SIGNATURE<br><b>Joseph D. Connor, M.D.</b>  |  |   |  |   | DEGREE<br><b>ATTENDING PHYSICIAN</b>   |   | MEDICAL DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> STAFF <input type="checkbox"/>                |  | 22c. DATE SIGNED<br><b>June 24 1981</b> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOSEPH D. CONNOR, MD</b>   |  |   |  |   | 22e. ADDRESS<br><b>9420 OLD GEORGETOWN RD Bethesda Md. 20814</b>                     |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>June 27 '81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Washington D.C.</b>                |  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>DeVol Funeral Home</b> ADDRESS <b>2222 Wisc Ave</b>  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>6-28-81</b>                                      |   |  |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b> |

MEDICAL CERTIFICATION

29



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. (IMPORTANT: If item 21 is marked for item 18 shows any injury, or other traumatic event, the medical examiner must be notified.)

DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 6 3 4 5

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |   |   |                             |  |
|--|--|--|---|---|-----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>John Henry Lancaster</b>                            |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>June 20, 1981</b> |   | 2b. HOUR<br><b>11:55 AM</b> |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 9 19</b>   |                             |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS.</b>                            |   | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>11 55</b>  |                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Massachusetts</b>                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                            |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                             |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery Co. MD.</b>                          |  | 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>                             |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SUBURBAN Hosp.</b>                          |                             |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Marine Engineer</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Coast Gd.</b>               |   | 13a. STATE<br><b>Maryland</b>   |                             |  |
| 13b. COUNTY<br><b>Montgomery</b>   |  | 13c. CITY OR TOWN<br><b>Rockville</b>                                    |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                             |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Henry N. Lancaster</b>                        |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lottie S. Olsson</b> |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>yes WWII</b>   |                             |  |
| 16b. SOCIAL SECURITY NO.<br><b>096-16-5088</b>   |  | 17. INFORMANT<br><b>Margaret B. Lancaster (same as 13e)</b>              |   | ADDRESS   |                             |  |

|   |  |  |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>1629</b><br>IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>LUNG CARCINOMA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>1629</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 HOURS</b><br><b>2 YEARS</b> |
|---|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

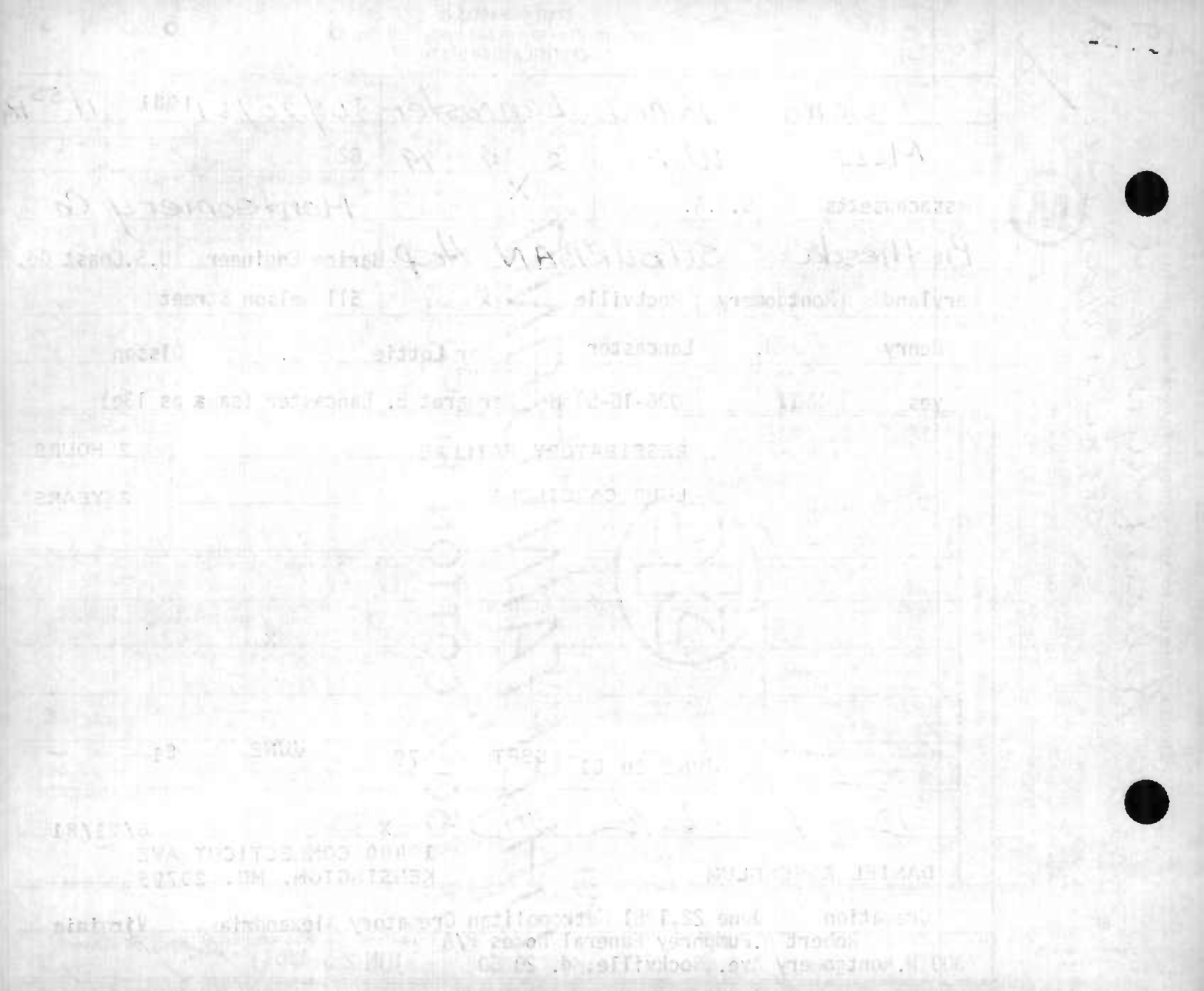
|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                      |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>JUNE 20, 81</b> to <b>SEPT 79</b> , 19 <b>79</b> , to <b>JUNE</b> , 1981, that (I) (we) last saw the deceased alive on <b>JUNE 20, 81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Daniel Rosenblum</b>   |  |   |  | DEGREE<br><b>M.D.</b>  |  | 22c. DATE SIGNED<br><b>6/21/81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DANIEL ROSENBLUM</b>  |  |   |  | 22e. ADDRESS<br><b>10400 CONNECTICUT AVE<br/>KENSINGTON, MB. 20795</b>               |  |  |  |

|  |  |                                   |  |   |  |  |  |
|--|--|-----------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b> |  | 23b. DATE<br><b>June 22, 1981</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Metropolitan Crematory Alexandria Virginia</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE       |  |
| 24. FUNERAL DIRECTOR <b>Robert A. Pumphrey</b>                   |  |                                   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 25 1981</b>                                     |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b> |  |
| 24. NAME<br><b>300 W. Montgomery Ave., Rockville, Md. 20850</b>  |  |                                   |  | 25b. ADDRESS  |  |  |  |

MEDICAL CERTIFICATION

1004

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-1234.

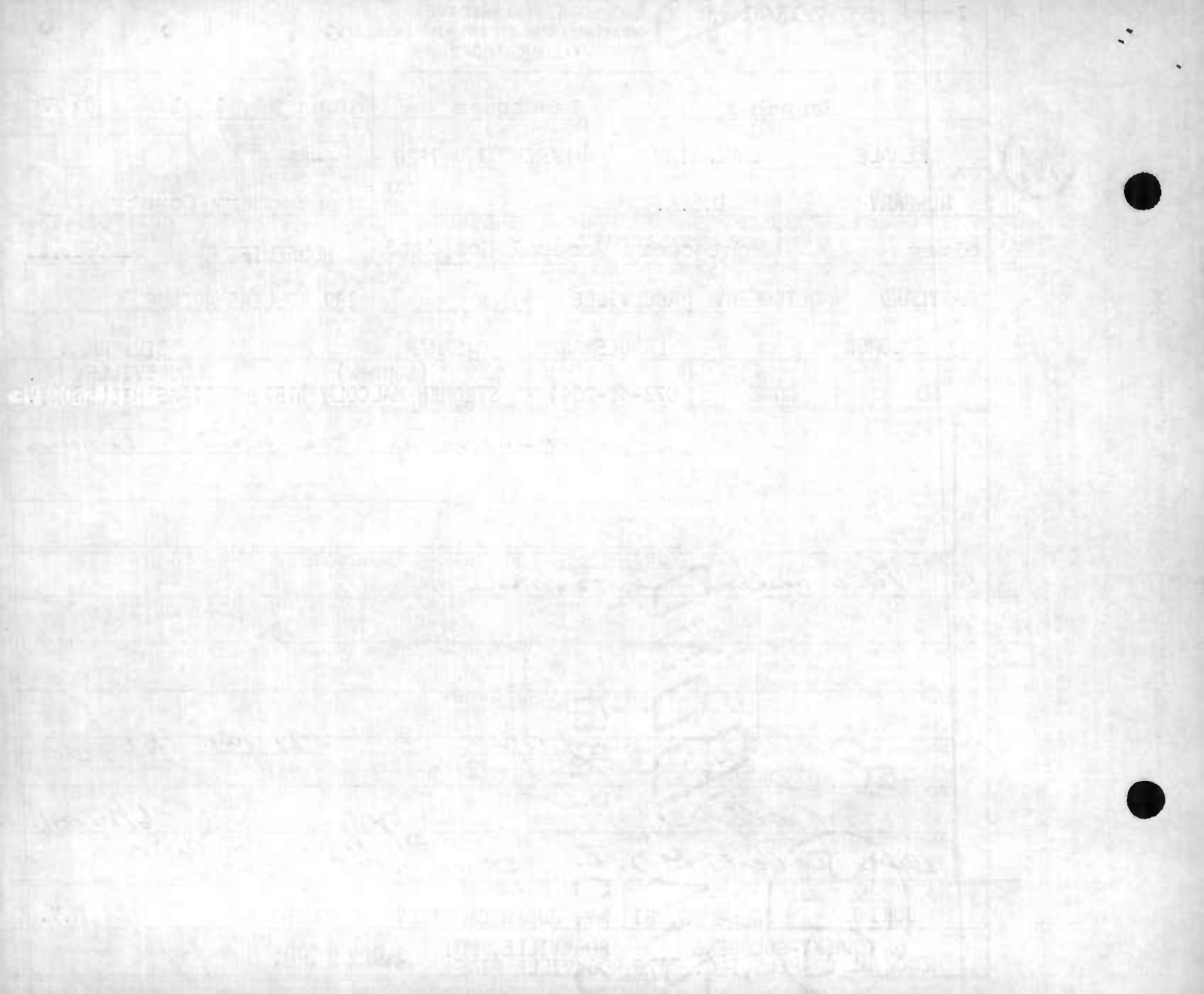
Item 6g557 7/13/81 gj

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |  |   |  |  |  |
|---|--|---|--|---|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Hannah Landesman</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>June 24, 1981</b>               |   |  | 2b. HOUR<br><b>9:07p<sub>M</sub></b>   |   |  |  |  |
| 3 SEX<br><b>FEMALE</b>  |  | 4 RACE<br><b>CAUCASIAN</b>  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>MARCH 7, 1888</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>93</b> YRS                                      |   | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>HUNGARY</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County</b> MD.                  |   |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Olney</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Montgomery General Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>-----   |  |  |
| 13a. STATE<br><b>MARYLAND</b>   |  |   | 13b. COUNTY<br><b>MONTGOMERY</b>                                       |   | 13c. CITY OR TOWN<br><b>ROCKVILLE</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>199 ROLLINS AVENUE</b> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>SOLOMON LANDESMAN</b>   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>SARAH SILVERMAN</b>   |   |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>NONE</b> |   | 17. INFORMANT (Nephew)<br><b>STEPHEN MALCOLM</b>                               |  | ADDRESS<br><b>BROOKEVILLE, MD. 18705 HERITAGE HILLS DR.</b>                                     |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b><br>4360<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hours</b> |  |   |  |   |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Myocardial Infarction</b>  |  |   |  |   |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)    |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>19 June 1981</b> to <b>24 June 1981</b> , that (I) (we) last saw the deceased alive on <b>24 June 1981</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.  |  |   |  |   |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>[Signature]</b>  |  |   | DEGREE   |   |  | 22c. DATE SIGNED<br><b>6/25/81</b>   |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Lewis Kellert, M.D.</b>   |  |   | 22e. ADDRESS<br><b>1811 Prince Phillip Dr. Olney, MD. 20832</b>        |   |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  |   | 23b. DATE<br><b>June 26, 81</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT. JUDAH CEMETERY</b>                |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>RIDGEWOOD N.Y.</b>                                |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.</b>   |  |   |  |   | ADDRESS<br><b>ROCKVILLE, MD. 1170 ROCKVILLE PIKE</b>                           |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 29 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b> |  |





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 2/80

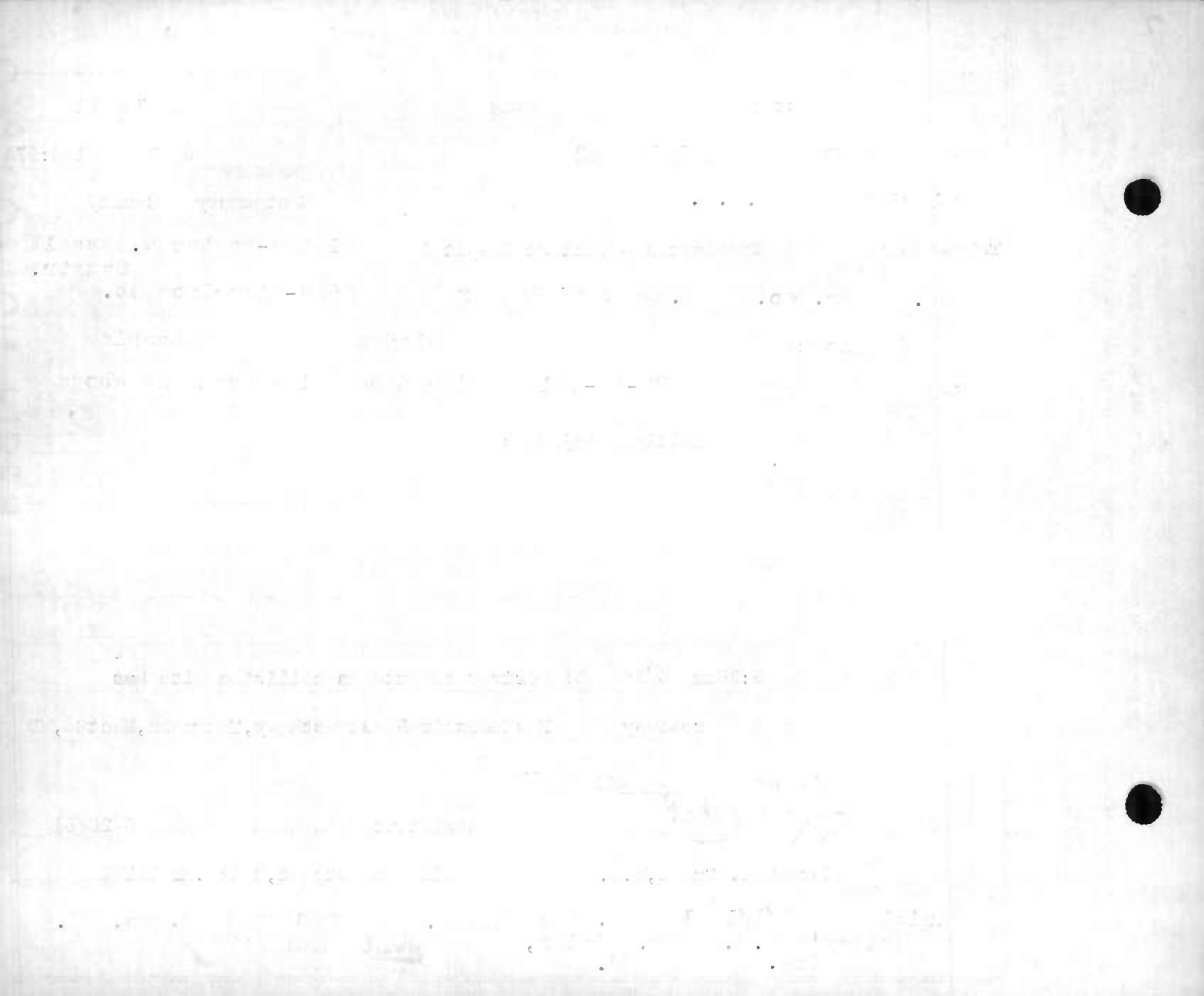
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |         |  |  |   |  |   |  |   |  |   |  |   |  |      |  |  |  |
|--|---------|--|--|---|--|---|--|---|--|---|--|---|--|------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST  |  | MIDDLE  |  | LAST  |  | 2a. DATE KNOWN OF DEATH   |  | <input checked="" type="checkbox"/> MONTH |  | DAY   |  | YEAR |  | 2b. HOUR                                     |  |
| Lester   |         |  |  |   |  | Lang  |  | 6   |  | 26  |  | 19  |  | 81   |  |  |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS.  |  | 7c. DATE PRONOUNCED DEAD                  |  | MONTH   |  | DAY  |  | YEAR   |  |
| male   | white   | May 4 1919   |  | 62 YRS.   |  |   |  |   |  | 6   |  | 26  |  | 19   |  | 81   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?                             |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |   |  |   |  |   |  |      |  |  |  |
| Virginia   |         | U.S.A.   |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    |  | Montgomery County   |  |   |  |   |  |   |  |      |  |  |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                         |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |   |  |   |  |   |  |      |  |  |  |
| Takoma Park  |         | Washington Adventist Hospital                            |  | Painter-Morton  |  | C. Russell  |  |   |  |   |  |   |  |      |  |  |  |
| 13a. STATE   |         | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS   |  |   |  |   |  |      |  |  |  |
| Md.  |         | Pr. Geo.   |  | W. Hyattsville  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 2609-Nicholson St.  |  |   |  |   |  |      |  |  |  |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME                                 |  |   |  |   |  |   |  |   |  |   |  |      |  |  |  |
| (Unknown)  |         | Gladys   |  | Morris  |  |   |  |   |  |   |  |   |  |      |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |         | 16b. SOCIAL SECURITY NO.                                 |  | 17. INFORMANT   |  | ADDRESS   |  |   |  |   |  |   |  |      |  |  |  |
| Yes  |         | WWII   |  | 579-10-9218   |  | Edith Lang (Wife)   |  | same as above   |  |   |  |   |  |      |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |  |  |   |  |   |  |   |  |   |  |   |  |      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I DEATH WAS CAUSED BY:  |         |  |  |   |  |   |  |   |  |   |  |   |  |      |  |  |  |
| IMMEDIATE CAUSE (a) Multiple injuries  |         |  |  |   |  |   |  |   |  |   |  |   |  |      |  |  |  |
| 8/20   |         |  |  |   |  |   |  |   |  |   |  |   |  |      |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:  |         |  |  |   |  |   |  |   |  |   |  |   |  |      |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |  |  |   |  |   |  |   |  |   |  |   |  |      |  |  |  |
| (b)  |         |  |  |   |  |   |  |   |  |   |  |   |  |      |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |  |  |   |  |   |  |   |  |   |  |   |  |      |  |  |  |
| (c)  |         |  |  |   |  |   |  |   |  |   |  |   |  |      |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |         |  |  |   |  |   |  |   |  |   |  |   |  |      |  |  |  |
| 19a. DATE OF OPERATION   |         |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                     |  |   |  |   |  |   |  | 20. AUTOPSY?  |  |      |  |  |  |
|  |         |  |  |   |  |   |  |   |  |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |      |  |  |  |
| 21a. EXTERNAL CAUSE WAS  |         |  |  | 21b. TIME OF INJURY   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |  |   |  |      |  |  |  |
| UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         |  |  | 6:20 PM 6/26/81   |  |   |  | driver of auto in collision with bus  |  |   |  |   |  |      |  |  |  |
| 21d. INJURY OCCURRED   |         |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                           |  |   |  | 21f. LOCATION   |  |   |  |   |  |      |  |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |         |  |  | roadway   |  |   |  | New Hampshire & East West Hwy, Takoma Park, Mont Co, MD                       |  |   |  |   |  |      |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |  |  |   |  |   |  |   |  |   |  |   |  |      |  |  |  |
| ACTUAL SIGNATURE   |         |  |  | TITLE (SPECIFY)   |  |   |  | DATE SIGNED   |  |   |  |   |  |      |  |  |  |
| H. R. Guard  |         |  |  | M.D. Assistant  |  |   |  | MEDICAL EXAMINER  |  |   |  | 6/28/81   |  |      |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |         |  |  | ADDRESS   |  |   |  |   |  |   |  |   |  |      |  |  |  |
| Hormez R. Guard, M.D.  |         |  |  | 111 Penn Street, Balto, MD 21201  |  |   |  |   |  |   |  |   |  |      |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         |  |  | 23b. DATE   |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |   |  | 23d. LOCATION   |  |      |  |  |  |
| Burial   |         |  |  | 7/1/1981  |  |   |  | Ft. Lincoln Cem.  |  |   |  | Brentwood Pr. Geo. Md.  |  |      |  |  |  |
| 24. FUNERAL DIRECTOR NAME  |         |  |  | 25a. D. RECD. BY REGISTRAR  |  |   |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |   |  |      |  |  |  |
| Valley's F.H. Inc.   |         |  |  | Mt. Rainier, Md.  |  |   |  | JUL 1 1981  |  |   |  |   |  |      |  |  |  |

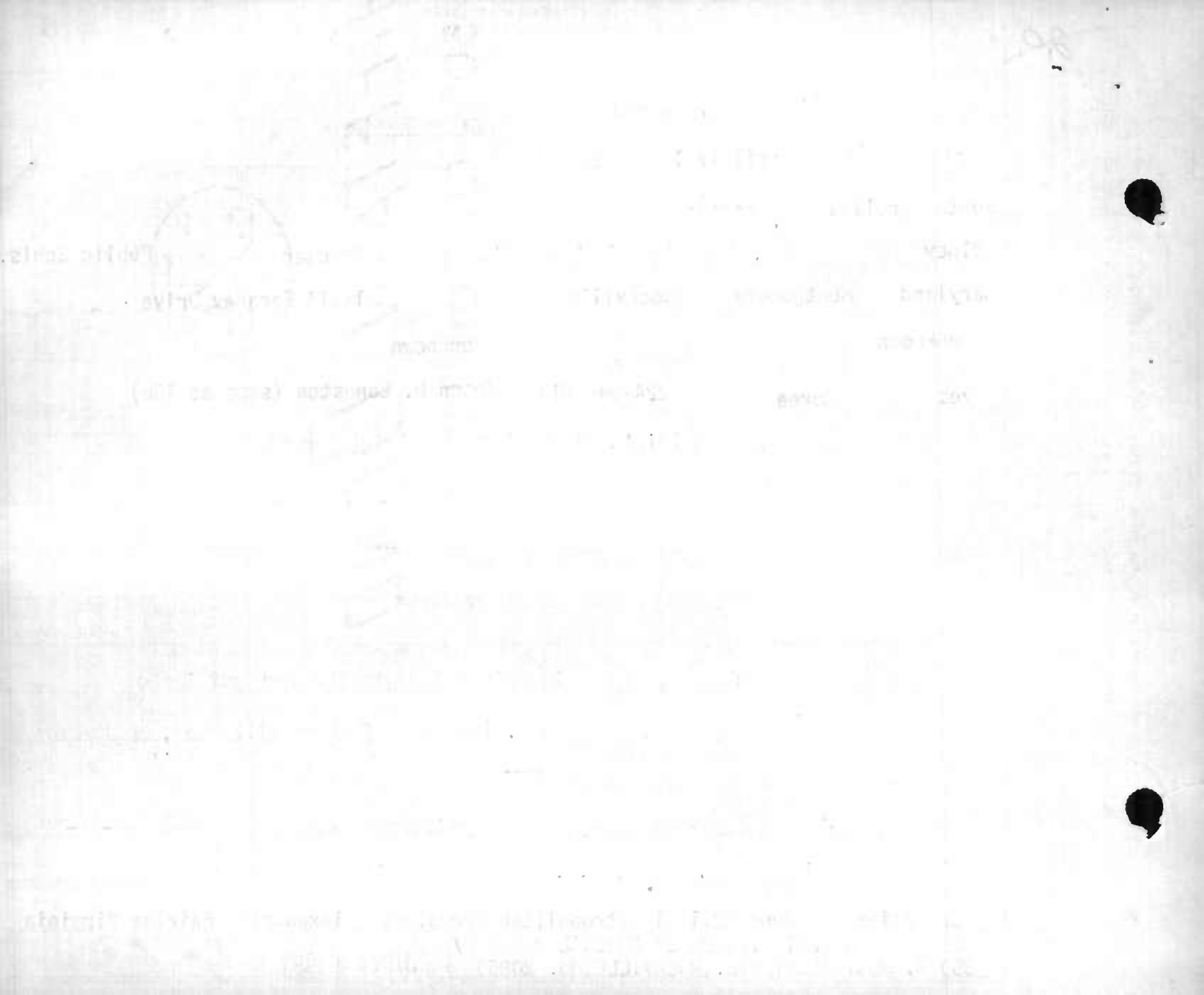




TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |             |  |   |  |   |  |  |  | REG. NO. 16348                            |  |   |  |                     |  |            |  |
|--|--|-------------|--|---|--|---|--|--|--|---|--|---|--|---------------------|--|------------|--|
| 1- FOR STATE REGISTRAR   |  |             |  |   |  | 2a. DATE KNOWN OF DEATH   |  |  |  |   |  | MONTH DAY YEAR  |  | HOUR                |  |            |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |             |  |   |  | 2b. DATE ESTI. MATED  |  |  |  |   |  | MONTH DAY YEAR  |  | HOUR                |  |            |  |
| William Greenwood Langston   |  |             |  |   |  | 6 20 1981   |  |  |  |   |  | 6 20 1981   |  | 2:25 P. M.          |  |            |  |
| 3. SEX   |  | 4. RACE     |  | 5. DATE OF BIRTH (MONTH DAY YEAR)   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YR.   |  | IF UNDER 24 HRS.                          |  | 7c. DATE PRONOUNCED DEAD  |  | MONTH DAY YEAR      |  | HOUR       |  |
| Male   |  | White       |  | April 17 1929   |  | 52 YRS.   |  | MONTHS DAYS  |  | HOURS MIN.                                |  | 6 20 1981   |  | 6 20 1981           |  | 2:25 P. M. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |             |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                     |  |            |  |
| South Carolina   |  |             |  | U.S.A.  |  |   |  |  |  |   |  | Montgomery County MD.   |  |                     |  |            |  |
| 10. CITY OR TOWN OF DEATH  |  |             |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                     |  |            |  |
| Olney  |  |             |  | Rt. 108 west of Olney Mill Road   |  |   |  | Teacher  |  |   |  | Public Schls.   |  |                     |  |            |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |             |  |   |  |   |  |  |  |   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS |  |            |  |
| 13a. STATE   |  | 13b. COUNTY |  | 13c. CITY OR TOWN   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 14514 Faraday Drive  |  |   |  |   |  |                     |  |            |  |
| 14. FATHER'S NAME (FIRST MIDDLE LAST)  |  |             |  |   |  | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)                        |  |  |  |   |  |   |  |                     |  |            |  |
| unknown  |  |             |  |   |  | unknown   |  |  |  |   |  |   |  |                     |  |            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |  |             |  |   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS  |  |   |  |   |  |                     |  |            |  |
| yes  |  |             |  |   |  | Korea   |  | 224-34-9819 Joann H. Langston (same as 13e)  |  |   |  |   |  |                     |  |            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |             |  |   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |                     |  |            |  |
| PART I DEATH WAS CAUSED BY:  |  |             |  |   |  |   |  |  |  |   |  |   |  |                     |  |            |  |
| IMMEDIATE CAUSE (a) Multiple visceral and skeletal injuries  |  |             |  |   |  |   |  |  |  |   |  |   |  |                     |  |            |  |
| 8150   |  |             |  |   |  |   |  |  |  |   |  |   |  |                     |  |            |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:  |  |             |  |   |  |   |  |  |  |   |  |   |  |                     |  |            |  |
| (b)  |  |             |  |   |  |   |  |  |  |   |  |   |  |                     |  |            |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |             |  |   |  |   |  |  |  |   |  |   |  |                     |  |            |  |
| (c)  |  |             |  |   |  |   |  |  |  |   |  |   |  |                     |  |            |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |             |  |   |  |   |  |  |  |   |  |   |  |                     |  |            |  |
| 19a. DATE OF OPERATION   |  |             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |  |  |   |  | 20. AUTOPSY?  |  |                     |  |            |  |
|  |  |             |  |   |  |   |  |  |  |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                     |  |            |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |             |  | 21b. TIME OF INJURY (HOUR MONTH DAY YEAR)   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |   |  |                     |  |            |  |
|  |  |             |  | 2:09 P.M. 6 20 1981   |  |   |  | driver in auto/fixed object impact   |  |   |  |   |  |                     |  |            |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |             |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |   |  | 21f. LOCATION (STREET CITY OR TOWN COUNTY STATE)   |  |   |  |   |  |                     |  |            |  |
|  |  |             |  | road  |  |   |  | Rt. 108 west of Olney Mill Road, Montgomery Co., Maryland  |  |   |  |   |  |                     |  |            |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |             |  |   |  |   |  |  |  |   |  |   |  |                     |  |            |  |
| ACTUAL SIGNATURE Virginia L. Dolan   |  |             |  |   |  | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER                     |  |  |  |   |  | DATE SIGNED 6-21-81   |  |                     |  |            |  |
| EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.  |  |             |  |   |  | ADDRESS 111 Penn Street   |  |  |  |   |  |   |  |                     |  |            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |             |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY                                  |  |  |  | 23d. LOCATION (CITY OR TOWN COUNTY STATE) |  |   |  |                     |  |            |  |
| Cremation  |  |             |  | June 22, 1981   |  | Metropolitan Crematory  |  |  |  | Alexandria Fairfax Virginia               |  |   |  |                     |  |            |  |
| 24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES P/  |  |             |  |   |  | 25a. DATE REC'D. BY REGISTRAR                                       |  |  |  | 25b. REGISTRAR'S SIGNATURE                |  |   |  |                     |  |            |  |
| 300 W. MONTGOMERY AVE., ROCKVILLE, MD. 20850   |  |             |  |   |  | JUN 29 1981   |  |  |  | [Signature]                               |  |   |  |                     |  |            |  |



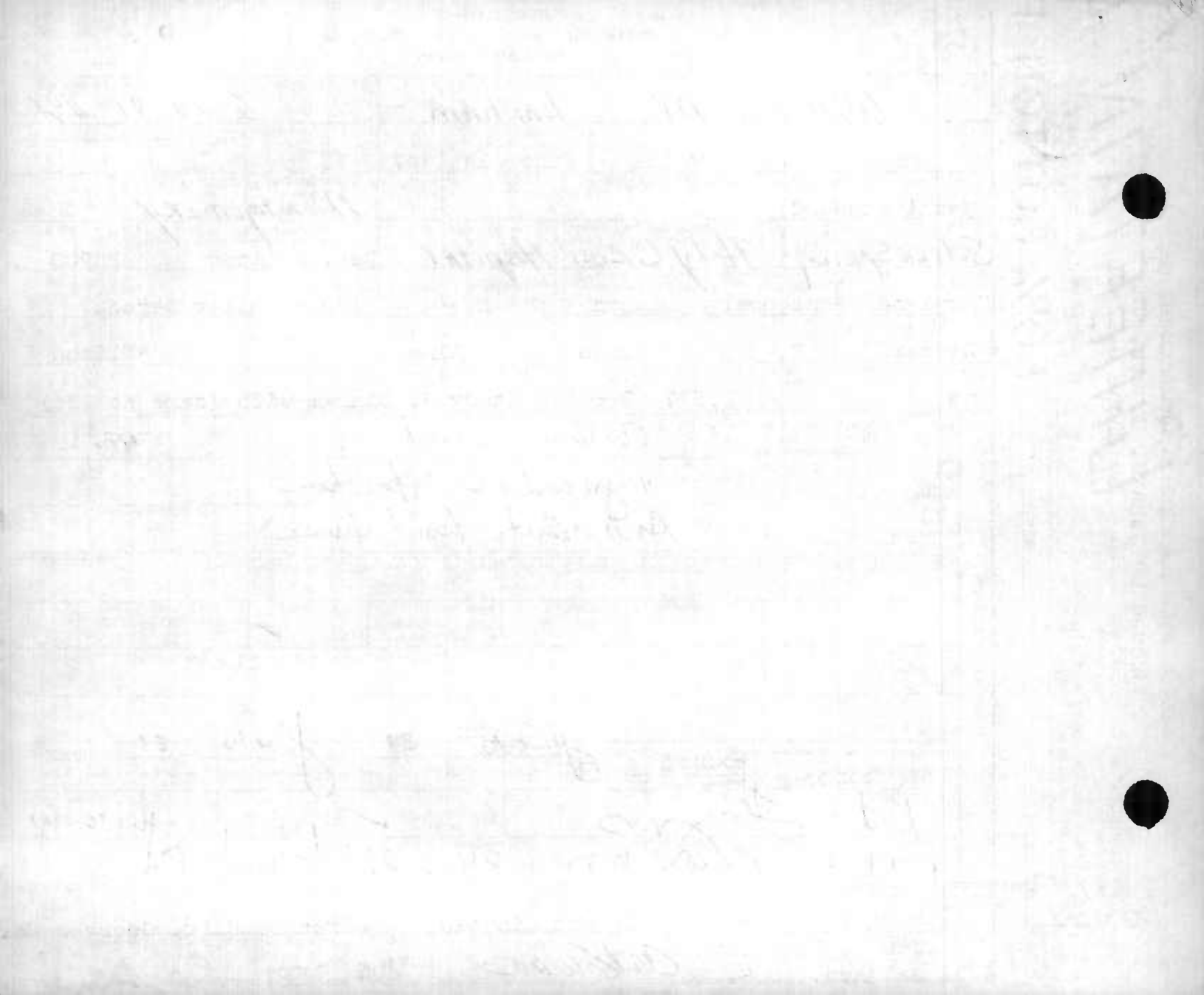
Approved by John S. Rogers, DME

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death be reported by phone 6-12-81 after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use on the burial-transit permit. This permit must be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |   |  |
|---|--|--|--|---|--|--|--|---|--|
| FOR<br>1. STATE REGISTRAR   |  |  |  |   | REG. NO.   |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>William M Lanham, SR.</i>   |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>6 10 81</i> |  |  | 2b. HOUR<br><i>4:45</i> M   |  |
| 3. SEX<br><i>Male</i>   |  | 4. RACE<br><i>white</i>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>June 18 1907</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>73</i> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Washington, DC</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Montgomery</i> MD.  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Silver Spring</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Holy Cross Hospital</i> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FORMER OR WORKING LIFE)<br><i>Ret. Splicer</i>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>PEPCO</i>   |  |
| 13a. STATE<br><i>Maryland</i>   |  | 13b. COUNTY<br><i>Montgomery</i>   |  | 13c. CITY OR TOWN<br><i>Wheaton</i>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><i>12210 Fuller Street,</i>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>Leonard F. Lanham</i>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Alma Allison</i>   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><i>no</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>---</i>   |  | 17. INFORMANT ADDRESS<br><i>Nancy J. Lanham-wife-(same as 13e)</i>  |  |  |  |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><i>4100 Cardiac arrest</i><br>IMMEDIATE CAUSE (a) <i>Myocardial infarction</i><br>(b) <i>Arteriosclerotic heart disease</i><br>(c) <i>Arteriosclerotic heart disease</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><i>11-11-81</i>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><i>11-11-81</i>   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br><i>11-11-81</i>   |  |  |  |   |  |
| 22a. I certify that (1) <i>12-10-81</i> attended the deceased from <i>12-10-81</i> to <i>12-10-81</i> , that (1) <i>12-10-81</i> saw the deceased alive on above, (2) <i>12-10-81</i> saw the body after death.   |  |  |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><i>Kirk E. Pumphrey</i>   |  |  |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><i>June 10, 1981</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>KIRK E Pumphrey MD</i>  |  |  |  | 22e. ADDRESS<br><i>9410 Old Georgetown Rd</i>   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>  |  | 23b. DATE<br><i>6-12-1981</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Fort Lincoln</i>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><i>Brentwood Pr. Georges Md.</i>  |  |   |  |
| 24. FUNERAL DIRECTOR<br><i>Warner E. Pumphrey, Inc.</i>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>JUN 15 1981</i>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Clark W. War</i>  |  |   |  |
| 24. FUNERAL DIRECTOR<br><i>8434 Ga. Ave., S.S. Md.</i>  |  |  |  |   |  |  |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |   |   |   |  |  |
|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ROY O. LARSON</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6 9 81</b>  |  | 2b. HOUR<br><b>8:45 AM</b>                               |
| 3. SEX<br><b>MALE</b>   |   | 4. RACE<br><b>CAUCASIAN</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JULY 28, 1912</b>                                      |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS.        |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>WISCONSIN</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.                                |  |
| 10. CITY OR TOWN OF DEATH<br><b>SILVER SPRING</b>   |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>HOLY CROSS HOSP.</b>                        |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>ENGINEER</b>          | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>JOHN HOPKINS</b> |
| 13a. STATE<br><b>MARYLAND</b>   | 13b. COUNTY<br><b>MONTGOMERY</b>              | 13c. CITY OR TOWN<br><b>SILVER SPRING</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>9408 THORNHILL ROAD</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ANDREW LARSON</b>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE<br><b>IDA MALLORY</b>                                  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>395-14-5049</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>LORRAINE O. LARSON SAME AS 13 WIFE</b>                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Brain stem stroke</b><br>4360<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>48 hours</b> |   |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____   |   |   |   |  |  |
| 19a. DATE OF OPERATION<br>_____   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>_____   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                    |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |   |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>None</b> |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6/2/81</b> , 19____, to <b>6/9/81</b> , 19____, that (I) (we) lost saw the deceased alive on <b>6/2/81</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Howard Ailey</b>   |   | DEGREE  |   | 22c. DATE SIGNED<br><b>6/9/81</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HOWARD AILEY</b>  |   | 22e. ADDRESS<br><b>5454 WISCONSIN AVE, CLC RD.</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |   | 23b. DATE<br><b>6/13/81</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GATE OF HEAVEN</b>                                  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>SILVER SPRING MONT MD.</b>   |   |   |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>FRANCIS J. COLLINS</b><br>ADDRESS<br><b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>  |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 12 1981</b>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |  |                                    |  |   |                          |  | 8 1 1 6 3 5 1  |   |                                   |                     |  |
|--|--|---|--|--|------------------------------------|--|---|--------------------------|--|--|---|-----------------------------------|---------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |   |  |  | CERTIFICATE OF DEATH               |  |   |                          |  |  |   |                                   |                     |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   |  |  | 2a. DATE OF DEATH                  |  |   |                          |  | 2b. HOUR   |   |                                   |                     |  |
| Edward G. Lauterbach   |  |   |  |  | 6-30-81                            |  |   |                          |  | 120 AM   |   |                                   |                     |  |
| 3 SEX  |  | 4 RACE  |  | 5 DATE OF BIRTH  |                                    |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                      |                          | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS   |                                   |                     |  |
| Male   |  | Caucasian   |  | 9 21 90  |                                    |  | 91  |                          | MONTHS DAYS  |  | HOURS MIN.  |                                   |                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |                          |  |  |   |                                   |                     |  |
| Maryland   |  | USA   |  |  |                                    |  | Montgomery MD.  |                          |  |  |   |                                   |                     |  |
| 10 CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |                                    |  |   |                          |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b. KIND OF BUSINESS OR INDUSTRY |                     |  |
| Bethesda   |  | Bethesda Health Center  |  |  |                                    |  |   |                          |  | Retired Sales  |   | General Mills                     |                     |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |  | 13a. STATE                         |  | 13b. COUNTY   |                          | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |                                   | 13e. STREET ADDRESS |  |
|  |  |   |  |  | MD                                 |  | Montgomery  |                          | Silver Spring  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   | 11504 Seward Ave    |  |
| 14 FATHER'S NAME   |  |   |  |  | 15 MOTHER'S MAIDEN NAME            |  |   |                          |  |  |   |                                   |                     |  |
| Edward G. Lauterbach   |  |   |  |  | Caroline Grimm                     |  |   |                          |  |  |   |                                   |                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |   |  |  | 16b. SOCIAL SECURITY NO.           |  | 17 INFORMANT  |                          |  | ADDRESS  |   |                                   |                     |  |
| Yes  |  |   |  |  | WW 1                               |  | (Son-in-law)  |                          |  | Rockv.   |   |                                   |                     |  |
|  |  |   |  |  | 577-07-5999                        |  | Glen C. Leach   |                          |  | 11201 Buckwood Lane, Md.   |   |                                   |                     |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY   |  |   |  |  |                                    |  |   |                          |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                  |   |                                   |                     |  |
| IMMEDIATE CAUSE (a) <u>Pneumonia Sepsis</u>  |  |   |  |  |                                    |  |   |                          |  | 3 days   |   |                                   |                     |  |
| 5990 DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |  |                                    |  |   |                          |  |  |   |                                   |                     |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |   |  |  |                                    |  |   |                          |  |  |   |                                   |                     |  |
| (b) <u>urinary tract infection</u>   |  |   |  |  |                                    |  |   |                          |  |  |   |                                   |                     |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |  |                                    |  |   |                          |  |  |   |                                   |                     |  |
| (c)  |  |   |  |  |                                    |  |   |                          |  |  |   |                                   |                     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |                                    |  |   |                          |  |  |   |                                   |                     |  |
| <u>Organic Brain Syndrome</u>  |  |   |  |  |                                    |  |   |                          |  |  |   |                                   |                     |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |                                    |  | 20a. AUTOPSY?   |                          | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |   |                                   |                     |  |
|  |  |   |  |  |                                    |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                          | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |   |                                   |                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR                        |  |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |                          |  |  |   |                                   |                     |  |
|  |  |   | P.M. 19  |  |                                    |  |   |                          |  |  |   |                                   |                     |  |
| 21d. INJURY OCCURRED   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |                                    | 21f. LOCATION  |   |                          |  |  |   |                                   |                     |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   |  |  |                                    | STREET CITY OR TOWN COUNTY STATE   |   |                          |  |  |   |                                   |                     |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>6-9</u> 19 <u>81</u> , to <u>6-30</u> 19 <u>81</u> , that (1) (we) last saw the deceased alive on <u>6-28</u> 19 <u>81</u> , and that in (a) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. |  |   |  |  |                                    |  |   |                          |  |  |   |                                   |                     |  |
| 22b. SIGNATURE   |  |   | DEGREE   |  |                                    | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |                          | 22c. DATE SIGNED   |  |   |                                   |                     |  |
| <u>James Brodsky</u>   |  |   | MD   |  |                                    |  |   |                          | 6-30-81  |  |   |                                   |                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   | 22e. ADDRESS   |  |                                    |  |   |                          |  |  |   |                                   |                     |  |
| <u>James Brodsky</u>   |  |   | MD   |  |                                    | 4701 Willard Ave Chevy Chase, Md.  |   |                          |  |  |   |                                   |                     |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  |   | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY |  |   | 23d. LOCATION            |  |  |   |                                   |                     |  |
| Burial   |  |   | 7-2-1981   |  | Parklawn Cemetery                  |  |   | Rockville Montgomery Md. |  |  |   |                                   |                     |  |
| 24 FUNERAL DIRECTOR<br>NAME  |  |   |  |  |                                    |  |   |                          |  |  |   |                                   |                     |  |
| <u>Warner E. Pumphrey, Inc</u>   |  |   |  |  |                                    |  |   |                          |  |  |   |                                   |                     |  |
| 25a. DATE REC'D. BY REGISTRAR  |  |   |  |  |                                    |  |   |                          |  |  |   |                                   |                     |  |
| JUL 1 - 1981   |  |   |  |  |                                    |  |   |                          |  |  |   |                                   |                     |  |
| 25b. REGISTRAR'S SIGNATURE   |  |   |  |  |                                    |  |   |                          |  |  |   |                                   |                     |  |
| <u>Barbara M. Brady</u>  |  |   |  |  |                                    |  |   |                          |  |  |   |                                   |                     |  |

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TO HOSPITAL-ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO.   |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>ELIZABETH M. LEMIEUX  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>JUNE 10 81  |  | 2b. HOUR<br>12:55 PM  |  |
| 3 SEX<br>FEMALE  |  | 4 RACE<br>CAUCASIAN   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>JULY 2, 1900  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>80 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VIRGINIA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY MD.   |  |
| 10 CITY OR TOWN OF DEATH<br>TAKOMA PARK  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SLIGO GARDENS NURSING HOME |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RETAIL CLERK   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MARYLAND  |  |   |  | 13b. COUNTY<br>PRINCE GEORGE   |  | 13c. CITY OR TOWN<br>BERKSHIRE  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>ROBERT L. DAVIS   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ELLA P. UNKNOWN   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>236-46-4926  |  | 17 INFORMANT<br>MARGARET L. FAHV SAME AS 13 DAUGHTER   |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CEREBROVASCULAR OCCLUSION<br>4349<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) ARTERIO SCLEROTIC VASCULAR DISEASE<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                      |  |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>6 MO   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from 18 DEC 19 80 to 10 JUNE 19 81, that (we) last saw the deceased alive on 4 JUNE 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br>Walter E. Goetz MD   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |  | 22c. DATE SIGNED<br>11 JUNE 81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>WALTER E. GOETZ MD  |  |   |  | 22e. ADDRESS<br>2309 SHOREFIELD RD   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  | 23b. DATE<br>6/13/81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>GATE OF HEAVEN   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>SILVER SPRING MONT MD.  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>FRANCIS J. COLLINS  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 12 1981   |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |  |
| 500 UNIV. BLVD., W. SILVER SPRING, MD. 20901   |  |   |  |  |  |   |  |

18-20-11

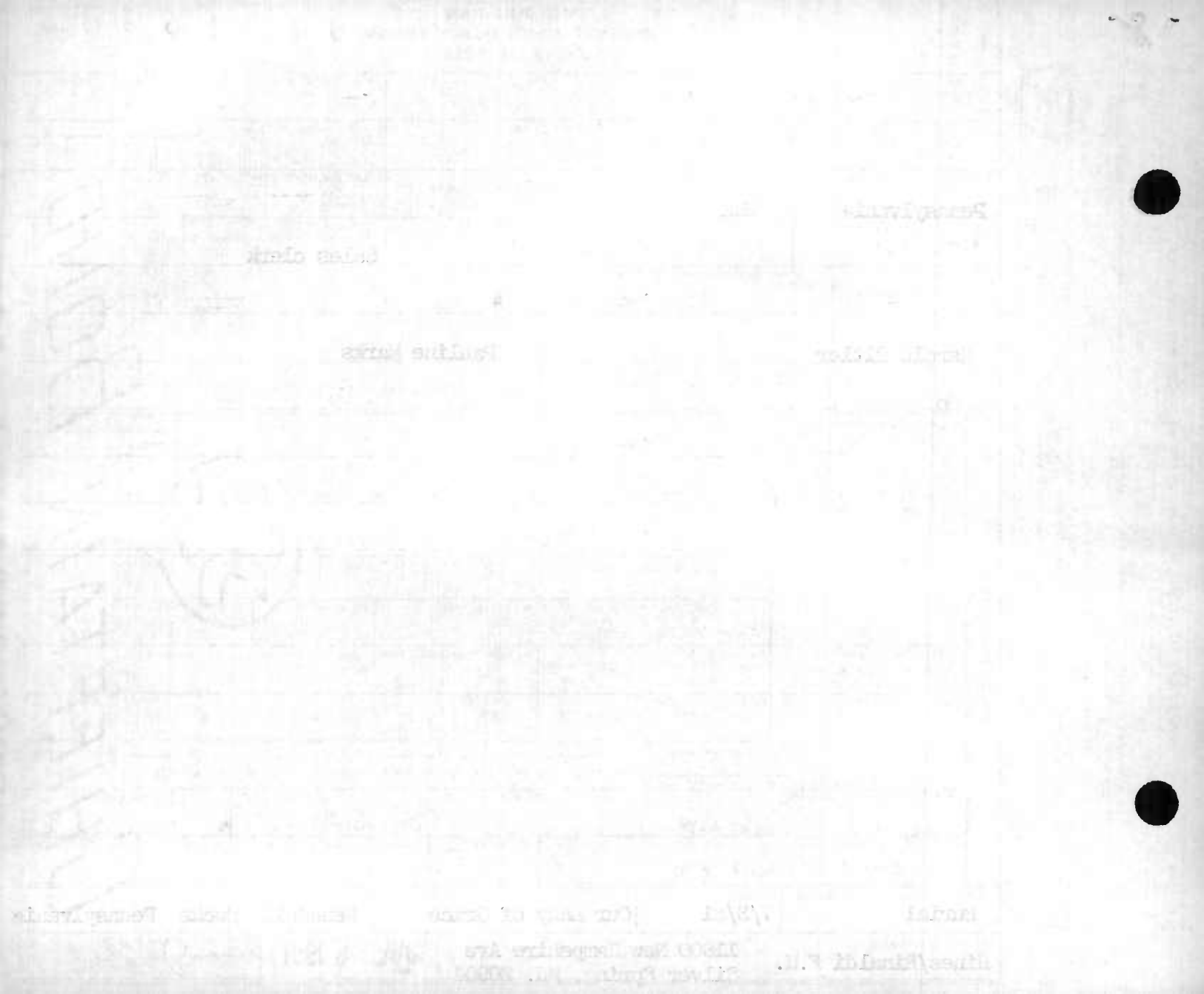
FOR SALE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

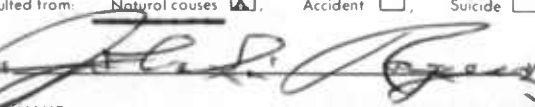
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

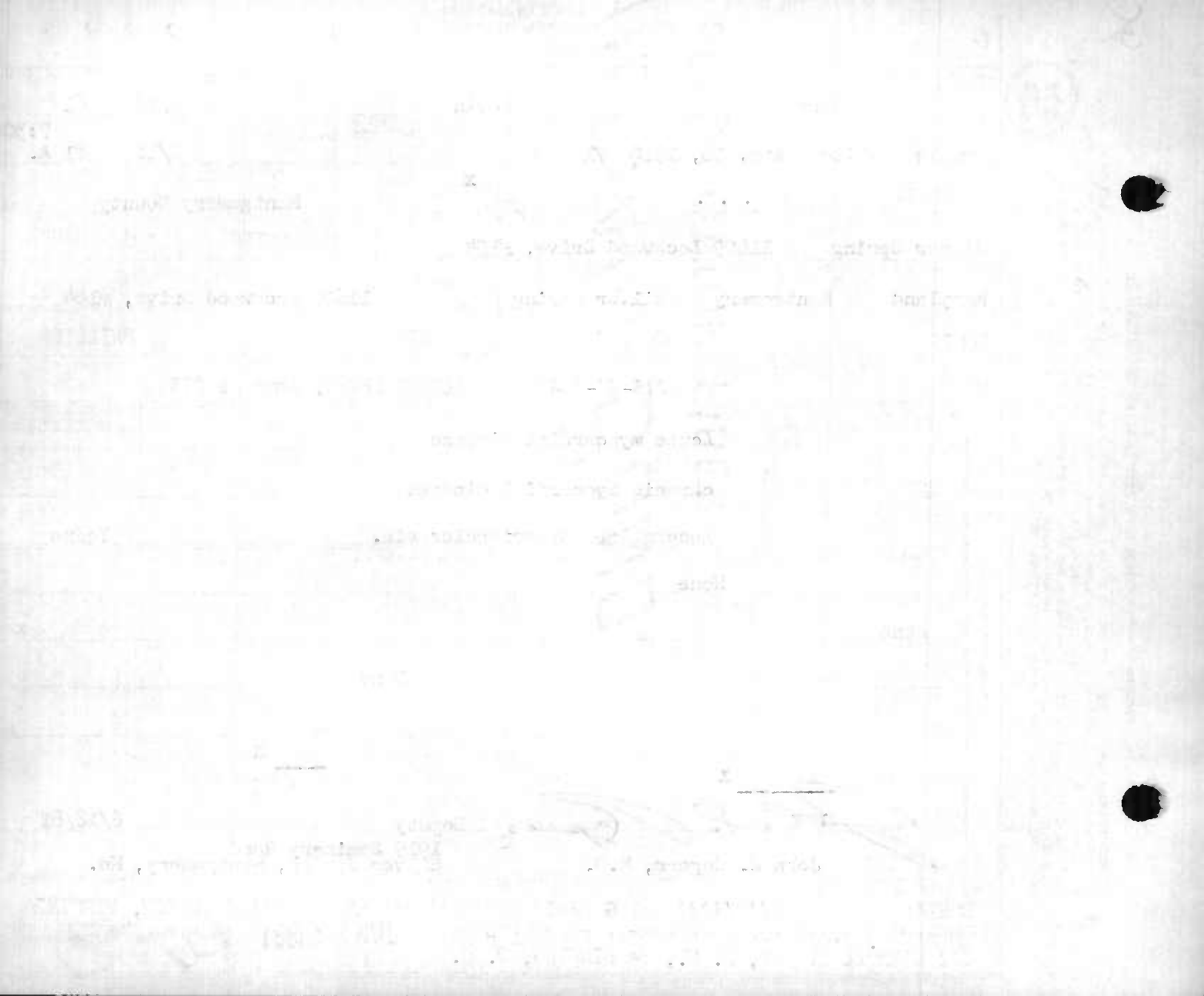
| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |   |   |  |   |  | REG. NO.   |  |
|--|--|--|--|---|---|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR                            |   |  |   |  | 2b. HOUR a M   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Barbara Louise Lemma   |  |  |  |   | June 29, 1981   |   |  |   |  | 6:25 a M   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Dec. 17, 1955  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>25 YRS   |  | 7. IF UNDER 1 YEAR MONTHS DAYS  |  | 7. IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County, MD.                                  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Clinical Center (NIH)                      |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Sales clerk                    |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. STATE<br>Pennsylvania   |  | 13b. COUNTY<br>Southampton   |  | 13c. CITY OR TOWN<br>Southampton  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>826 Grove Avenue 18966   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Harold Bitler   |  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Pauline Marks |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>176-38-9235  |  | 17. INFORMANT ADDRESS<br>Mr. ANTHONY LEMMA (husband) same as above  |   |   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Status Post Aortic Valve Replacement</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Idiopathic hypertrophic subaortic stenosis; S/P left ventricular myotomy/myectomy</u>  |  |  |  |   |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Minutes<br>Days<br>Years |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br>June 19, 1981  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Aortic Regurgitation   |  |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |   |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 18, 1981, to June 29, 1981, that <input checked="" type="checkbox"/> (we) saw the deceased alive on June 29, 1981, and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) (not) view the body after death. |  |  |  |   |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Leland Siwek MD  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   |   |   |  | 22c. DATE SIGNED<br>June 30, 1981   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>LELAND SIWEK, MD  |  |  |  | 22e. ADDRESS<br>National Institutes of Health<br>Clinical Center, Bethesda, Md 20205  |   |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>Burial  |  | 23b. DATE<br>7/3/81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Our Lady of Grace   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Pennell Bucks Pennsylvania                        |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Hines/Rinaldi F.H.   |  |  |  | 11800 New Hampshire Ave<br>Silver Spring, Md. 20904   |   | 25a. DATE REC'D BY REGISTRAR<br>JUL 8 1981  |  | 25b. REGISTRAR'S SIGNATURE<br>James J. Martin   |  |  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                      |  |   |   |                                |   |  |   |  | REG. NO. 16354 |  |
|---|----------------------|--|---|---|--------------------------------|---|--|---|--|----------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Rose</b> <b>Levin</b>  |                      |  |   |   |                                | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> <b>6/18</b> 19 <b>81</b> |  | 2b. HOUR <b>7:50</b>  |  |                |  |
| 3. SEX <b>Female</b>  | 4. RACE <b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>Apr. 18, 1910</b>  | 6. AGE IN YEARS<br>(LAST BIRTHDAY) <b>71</b> YRS.                           | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS.<br>HOURS MIN. | 2c. DATE PRONOUNCED DEAD <b>6/18</b> 19 <b>81</b>   |  | 2d. HOUR <b>A.</b>  |  |                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>   |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b>   |  |   |  |                |  |
| 10. CITY OR TOWN OF DEATH <b>Silver Spring</b>  |                      | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>11609 Lockwood Drive, #104</b> |   |   |                                | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING TIME) <b>HOUSEWIFE</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>   |  |                |  |
| 13a. STATE <b>Maryland</b>  |                      | 13b. COUNTY <b>Montgomery</b>  |   | 13c. CITY OR TOWN <b>Silver Spring</b>  |                                | 13d. INSIDE CITY LIMITS? <b>Yes</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>              |  | 13e. STREET ADDRESS <b>11609 Lockwood Drive, #104</b>   |  |                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>LOUIS</b> <b>GORDON</b>   |                      |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>FANNIE</b> <b>PHILLIPS</b> |   |                                |   |  |   |  |                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>NO</b>   |                      | 16b. SOCIAL SECURITY NO. <b>213-44-4848</b>  |   | 17. INFORMANT ADDRESS <b>ALBERT LEVIN, same as #13</b>  |                                |   |  |   |  |                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute myocardial disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>chronic myocardial disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>generalized arteriosclerosis.</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>   |                      |  |   |   |                                |   |  |   |  |                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).<br><b>None</b>  |                      |  |   |   |                                |   |  |   |  |                |  |
| 19a. DATE OF OPERATION <b>None</b>  |                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |   |                                |   |  | 20. AUTOPSY?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/> |  |                |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                      | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>None</b>  |                                |   |  |   |  |                |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |                      | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                |   |  |   |  |                |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                      |  |   |   |                                |   |  |   |  |                |  |
| ACTUAL SIGNATURE   |                      | TITLE (SPECIFY) <b>Deputy</b> MEDICAL EXAMINER   |   |   |                                | DATE SIGNED <b>6/18/81</b>  |  |   |  |                |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers, M.D.</b>   |                      | ADDRESS <b>1919 Seminary Road Silver Spring, Montgomery, Md.</b>   |   |   |                                |   |  |   |  |                |  |
| 23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>   |                      | 23b. DATE <b>6/19/1981</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY <b>KING DAVID MEMORIAL GARDEN</b>  |                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>FALLS CHURCH, VIRGINIA</b>  |  |   |  |                |  |
| 24. FUNERAL DIRECTOR <b>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME</b><br><b>232 CARROLL STREET, N. W., WASHINGTON, D. C.</b>   |                      |  |   |   |                                |   |  |   |  |                |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |   |  |   |  |                                  |
|---|---|--|---|--|----------------------------------|
| 1- FOR<br>STATE<br>REGISTRAR  |   | 2a DATE OF DEATH MONTH DAY YEAR  |   | 2b HOUR  |                                  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)  |   | JAY MICHAEL LEWIS  |   | JUNE 8, 1981 1008 AM   |                                  |
| 3 SEX   | 4 RACE  | 5 DATE OF BIRTH<br>MONTH DAY YEAR  | 6 AGE (IN YEARS LAST BIRTHDAY)                                      | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                    |                                  |
| MALE  | CAUCASIAN   | FEBRUARY 7, 1980   | 1 YRS.  |  |                                  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b CITIZEN OF WHAT COUNTRY?   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |  |                                  |
| South Carolina<br>BEUFORD, SC   | U.S.A.  |  | BETHESDA Montgomery Co. MD.   |  |                                  |
| 10 CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)     |  | 12b KIND OF BUSINESS OR INDUSTRY |
| BETHESDA  | NATNAVMEDCEN BETHESDA MD  |  | Student   |  | School                           |
| 13a STATE   |   | 13b COUNTY   | 13c CITY OR TOWN  | 13d INSIDE CITY LIMITS?  |                                  |
| VIRGINIA  | FAIRFAX   | FALLS CHURCH   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e STREET ADDRESS   |                                  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST  |   |  |                                  |
| CARL NORDWALL LEWIS   |   | JOYCE MARIE GLASS  |   |  |                                  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |   | 16b SOCIAL SECURITY NO.  |   | 17 INFORMANT ADDRESS   |                                  |
| NO None   |   | None   |   | CARL N. LEWIS 3032 SEVEN OAKS PL Falls Church Va. ch                         |                                  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u><br><u>4275</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |   |  |   |  |                                  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____  |   |  |   |  |                                  |
| 19a DATE OF OPERATION   |   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a AUTOPSY?   |                                  |
| 8 JUNE 1981   |   | OPEN CHEST CARDIAC MESSAGE   |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>          |                                  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |   | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                                  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                            |                                  |
| 22a I certify that (I) (this hospital) attended the deceased from <u>May 28</u> , 19 <u>81</u> , to <u>June 8</u> , 19 <u>81</u> , that I (we) last saw the deceased alive on <u>June 8</u> , 19 <u>81</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |   |  |   |  |                                  |
| 22b SIGNATURE<br><i>J. H. Nading</i>  |   | DEGREE   |   | 22c DATE SIGNED  |                                  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                 |   | 6/8/81   |                                  |
| J. H. NADING  |   | 22e ADDRESS  |   |  |                                  |
|   |   | NATNAVMEDCEN BETHESDA MD   |   |  |                                  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SP)  |   | 23b DATE   |   | 23c NAME OF CEMETERY OR CREMATORY  |                                  |
| Burial  |   | June/11/81   |   | Memory Gardens Cemetery New Orleans, Orleans, La.                            |                                  |
| 24 FUNERAL DIRECTOR<br>NAME   |   | ADDRESS  |   | 25a DATE REC'D. BY REGISTRAR 25b REGISTRAR'S SIGNATURE                       |                                  |
| W. W. Chambers Co.  |   | Silver Spring, Md.   |   | JUN 12 1981  |                                  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 1 1 6 3 5 6  |  |   |   |
|---|--|--|--|--|--|---|---|
| 1. FOR STATE REGISTRAR  |  |  |  | REG. NO.   |  |   |   |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>SAUL F. LEWIS</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>6-13-81</b>   |  | 2b. HOUR MIN.<br><b>11:04 P M</b>   |   |
| 3. SEX<br><b>M</b>  |  | 4. RACE<br><b>W</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>11-2-93</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN.<br><b>87</b>  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY MD.</b>   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Holy Cross Hospital</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Merchant</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Shoe store</b>  |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. COUNTY 13d. CITY OR TOWN<br><b>MD MontGomery Silver Spring</b>   |  |  |  | 13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13f. STREET ADDRESS<br><b>8201-16th STREET</b>  |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>SCHOCHNA - - - LEWIS</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>HINDA ZELDA FINKLESTEIN</b>   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>YES</b>   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br><b>WW I</b>  |  | 17. INFORMANT ADDRESS<br><b>IRVING A. EISEN, 9516 CLEMENT RD. SILVER SPR. MD</b>   |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> 4100   |  |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>30 MIN</b> |
| DU TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Heart Disease</b>   |  |  |  |  |  |   | <b>10 yrs</b>   |
| DU TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |  |  |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.<br><b>DIABETES</b>   |  |  |  |  |  |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)   |  |   |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/30/81</b> 19 <b>1960</b> to <b>6/13/81</b> 19 <b>1981</b> , that (I) (we) last saw the deceased alive on <b>5/30/81</b> 19 <b>1981</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, fill in date and view the body after death.) |  |  |  |  |  |   |   |
| 22b. SIGNATURE DEGREE<br><b>Lewis H Biben MD</b>  |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED<br><b>6/13/81</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>LEWIS H BIBEN</b>   |  |  |  | 22e. ADDRESS<br><b>1145-19th ST NW Washington DC</b>   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>JUNE 16, '81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>B'NAI ISRAEL CEMETERY</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>OXEN HILL, MD.</b>  |   |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br><b>DANZANSKY - Goldberg MEM. CH., ROCKVILLE, MD.</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 17 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |   |

2601 BP

1901 12-11-2 24123 11 2412

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8 1 1 6 3 5 7  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1 - STATE REGISTRAR   |  |   |  | CERTIFICATE OF DEATH   |  |  |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)  |  |   |  | 2a DATE OF DEATH   |  |  |  |
| FIRST MIDDLE LAST<br><b>David Lieberman</b>   |  |   |  | MONTH DAY YEAR<br><b>6 10 81</b>   |  |  |  |
| 3 SEX<br><b>Male</b>  |  |   |  | 2b HOUR<br><b>3:35 AM</b>  |  |  |  |
| 4 RACE<br><b>White</b>  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>August 1, 1890</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>90</b> YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Hungary</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Silver Spring</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Holy Cross Hospital</b> |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Merchant</b>   |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>table Fruit &amp; Vege-</b>   |  |
| 13a STATE<br><b>Maryland</b>  |  | 13b COUNTY<br><b>Montgomery</b>   |  | 13c CITY OR TOWN<br><b>Silver Spring</b>   |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 13e STREET ADDRESS<br><b>11200 New Hampshire Ave. #503</b>  |  | 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Not Ascertainable</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Not Ascertainable</b>  |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  |
| 16b SOCIAL SECURITY NO.<br><b>102-30-6868</b>   |  | 17 INFORMANT<br>ADDRESS<br><b>13317 Tamarack Road</b><br><b>Judge Alvin Lieberman Silver Spring, Maryland</b>                           |  | 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia, bilateral, atypical</b><br><b>4860</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>undetermined</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>undetermined</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 month</b> |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><b>Arteriosclerotic cardiovascular disease</b> |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  | 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |
| 21e PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM, ETC.)   |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  | 21g I certify that (I) (the hospital) attended the deceased from <b>5-12, 19 81</b> to <b>6-9, 19 81</b> , that (I) (we) last saw the deceased alive on <b>6-9, 19 81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.   |  | 21h SIGNATURE<br><b>Jason Gelber, M.D.</b><br>DEGREE<br><b>M.D.</b>  |  |
| 21i PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JASON GELBER, M.D.</b>   |  | 21j ADDRESS<br><b>8830 CAMERON STREET<br/>SILVER SPRING, MD. 20910</b>  |  | 21k DATE SIGNED<br><b>6-10-81</b>  |  | 21l ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                                       |  |
| 23a BURIAL, CREMATION, REMOVAL<br><b>Burial</b>   |  | 23b DATE<br><b>6/11/1981</b>  |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Union Field Cemetery</b>   |  | 23d LOCATION<br><b>Brooklyn, New York</b> STATE  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Donald M. Stein Hebrew Memorial F.H.</b>  |  | 24b ADDRESS<br><b>232 Carroll Street, N. W. Washington, D. C.</b>   |  | 25a DATE REC'D. BY REGISTRAR<br><b>JUN 12 1981</b>   |  | 25b REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |

171

Memorandum  
To: Mr. [illegible]  
From: Mr. [illegible]  
Subject: [illegible]

1. [illegible]  
2. [illegible]  
3. [illegible]  
4. [illegible]  
5. [illegible]

6. [illegible]  
7. [illegible]  
8. [illegible]  
9. [illegible]  
10. [illegible]

11. [illegible]  
12. [illegible]  
13. [illegible]  
14. [illegible]  
15. [illegible]

16. [illegible]  
17. [illegible]  
18. [illegible]  
19. [illegible]  
20. [illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-1500.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |  |  |   |  |  |  | 8 1 1 6 3 5 8  |  |
|---|--|--|--|--|--|---|--|--|--|--|--|
| 1 - STATE REGISTRAR   |  |  |  |  |  |   |  |  |  | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>GASSIE LINDER</b>  |  |  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6/12/81</b>   |  | 2b. HOUR<br><b>2:45</b> PM   |  |  |  |
| 3 SEX<br><b>FEMALE</b>  |  | 4 RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 15 99</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b> YRS.   |  | 7. UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>RUSSIA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY, CO. MD.</b>                              |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>SILVER SPRING</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>HOLY CROSS Hosp.</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>MONTG.</b>   |  | 13c. CITY OR TOWN<br><b>SILVER SPR.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>8918 First Ave.</b>  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>SAMUEL STEINGART</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>BESSIE - SIEINGARI</b>   |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>UNKNOWN</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>059-10-5775</b>   |  | 17. INFORMANT (DAUGHTER) ADDRESS<br><b>RUTH EISENSTADT - (#01) 588-4839</b>                     |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>acute Myocardial Infarction</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>atherosclerotic Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 days</b><br><b>10 yr</b>  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>0</b>  |  |  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 6-12</b> , 19 <b>70</b> , to <b>6-12</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>6-12</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Bernard H. Ostrow</b>  |  |  |  |  |  | DEGREE  |  | 22c. DATE SIGNED<br><b>6-13-81</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BERNARD H. OSTROW</b>   |  |  |  |  |  | 22e. ADDRESS<br><b>5225 Pooks Hill Rd BETH, MD 20814</b>  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |  |  | 23b. DATE<br><b>6-14-81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King David Mem. Gdn.</b>                               |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Falls Church, Virginia</b>          |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Danzansky-Goldberg Chapels; 1170 Rockville Pike</b>  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 16 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                     |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 8 1 1 6 3 5 9  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | CERTIFICATE OF DEATH   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  | 2a. DATE OF DEATH  |  |  |  |
| PAUL W. LINDGREN   |  |  |  | 06-25-81 3:27 P.M.   |  |  |  |
| 3 SEX  |  | 4 RACE   |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |  |
| MALE   |  | WHITE  |  | 11-04-25   |  | 55 YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |
| New Hampshire  |  | U.S.A.   |  |  |  | Montgomery MD.   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| SILVER SPRING  |  | HOLY CROSS HOSPITAL  |  | Engineer   |  |  |  |
| 13a. STATE   |  |  |  | 13b. COUNTY  |  |  |  |
| Maryland   |  |  |  | Montgomery   |  |  |  |
| 14. FATHER'S NAME  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |
| Clary E. Lindgren  |  |  |  | Viola Holmquist  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  | 16b. SOCIAL SECURITY NO.   |  |  |  |
| yes  |  |  |  | WW II. 067145149   |  |  |  |
| 17. INFORMANT  |  |  |  | 2366 Glenmont Circle   |  |  |  |
|  |  |  |  | Louise Lindgren-Silver Spring, Md.   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a) Bleeding Esophageal varices  |  |  |  |  |  |  |  |
| 5715   |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Cirrhosis   |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |
|  |  | P.M. 19  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)                                       |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
|  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from June 23, 1981, to June 25, 1981, that (I) (we) lost saw the deceased alive on June 25, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE   |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED   |  |
| Blaine H. Eig  |  | M.D.   |  |  |  | June 26, 1981  |  |
| 22d. PHYSICIAN'S NAME  |  | 22e. ADDRESS   |  |  |  |  |  |
| Blaine H. Eig  |  | 9801 Longacre Rd Silver Spring, Md 20902   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                        |  |
| Burial   |  | 6-29-81  |  | Culpeper Nat'l.  |  | Culpeper, Virginia   |  |
| 24. FUNERAL DIRECTOR (NAME)  |  |  |  | 25a. DATE REC'D. BY REGISTRAR (NAME)   |  |  |  |
| Colonial Funeral Home  |  |  |  | JUL 6 1981   |  |  |  |

Massachusetts

New Hampshire

Engineer

2386 Glenmont Circle

Maryland Montgomery Silver Sp.

2386 Glenmont Circle  
Wilmington  
Delaware

Wife

Wife

Wife

Wife

Wife

Wife

Colonial Church, Va.

Colonial Church, Va.

Colonial Church, Va.

Colonial Church, Va.

Colonial Church, Va.

Colonial Church, Va.

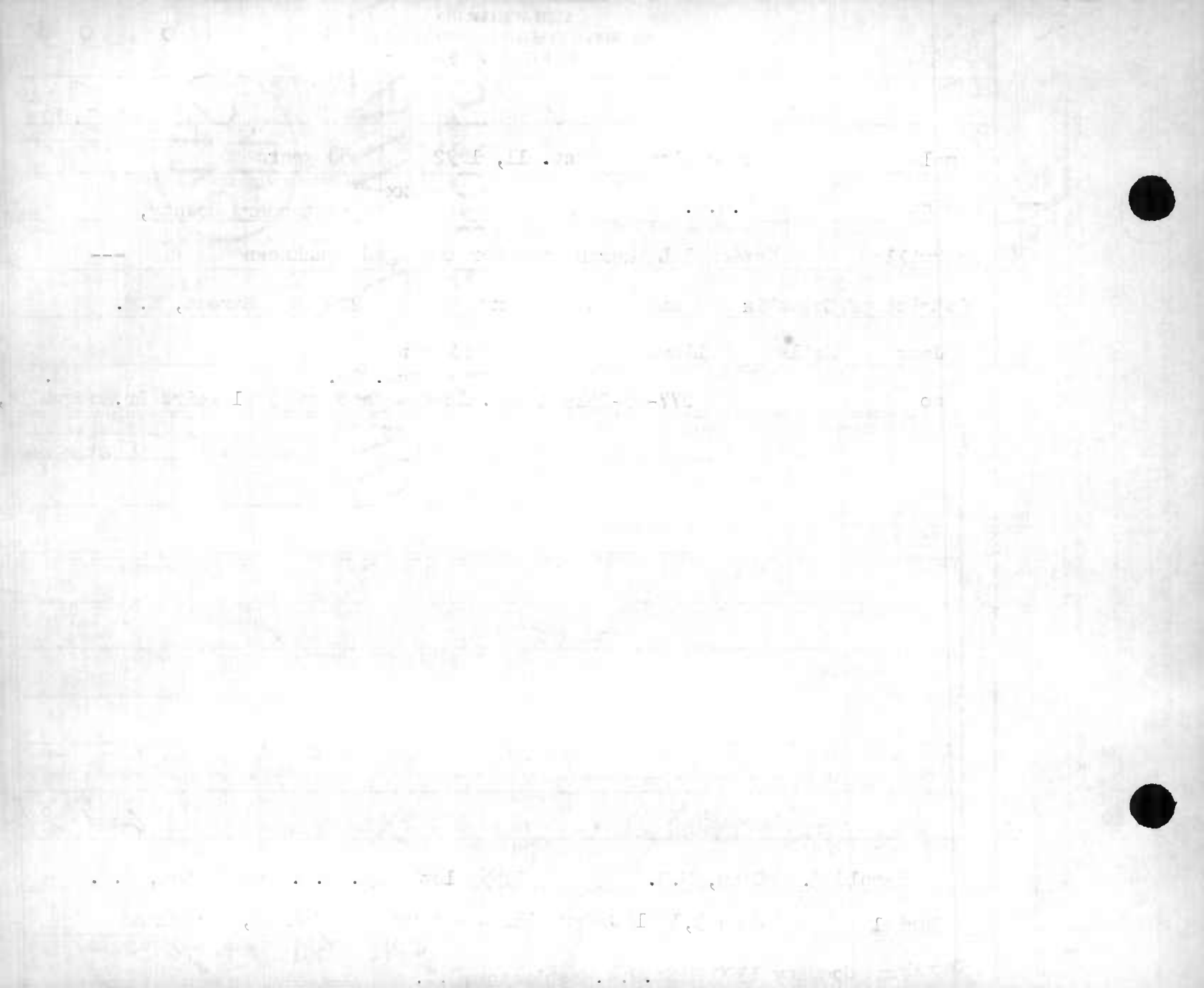
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the event.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 8 1 1 6 3 6 0  |  |
|--|--|---|--|--|--|
| 1- FOR STATE REGISTRAR   |  |   |  | CERTIFICATE OF DEATH   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |   |  | 2a. DATE OF DEATH  |  |
| FIRST MIDDLE LAST<br>Carl Linne  |  |   |  | MONTH DAY YEAR<br>6 1 81   |  |
| 3 SEX<br>male  |  | 4 RACE<br>caucasian   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>Oct. 11, 1892                                   |  |
| 6 AGE (IN YEARS LAST BIRTHDAY)<br>88 years   |  | 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Sweden  |  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |
| 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County, MD.   |  | 10 CITY OR TOWN OF DEATH<br>Rockville  |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>National Lutheran Home for the Aged   |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>unknown  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>---   |  |
| 13a STATE<br>District of Columbia  |  | 13b. COUNTY<br>Washington   |  | 13c. CITY OR TOWN<br>Washington  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Jans Neils Linne  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>unknown  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no  |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>277-05-2515 A   |  | 17 INFORMANT<br>Exec. Dir. Md.<br>Rev. Richard Reichard 9701 Veirs Dr. Rockville.    |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident</u><br>4360<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5 days                               |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |
| 19a DATE OF OPERATION<br>—   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>—   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)<br>21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19<br>21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br>21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK<br>21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE |  |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from <u>4-18</u> 19 <u>77</u> to <u>6-1</u> 19 <u>81</u> , that (I) <del>(we)</del> <u>last</u> saw the deceased alive on <u>5-30</u> 19 <u>81</u> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> <u>(did)</u> <u>(did not)</u> view the body after death. |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Harold F. McCann, M.D.</u><br>22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Harold F. McCann, M.D.   |  |   |  | 22c. DATE SIGNED<br>6-1-81   |  |
| 22e ADDRESS<br>3355 16th St. N.W. Washington, D.C.   |  |   |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b DATE<br>June 3, 1981  |  | 23c NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery                             |  |
| 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>Suitland, Maryland  |  |   |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>The Hysone Company 1300 N. St. N.W. Washington, D.C.  |  | 25. NAME OF REGISTRAR<br>JUN 8 1981   |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

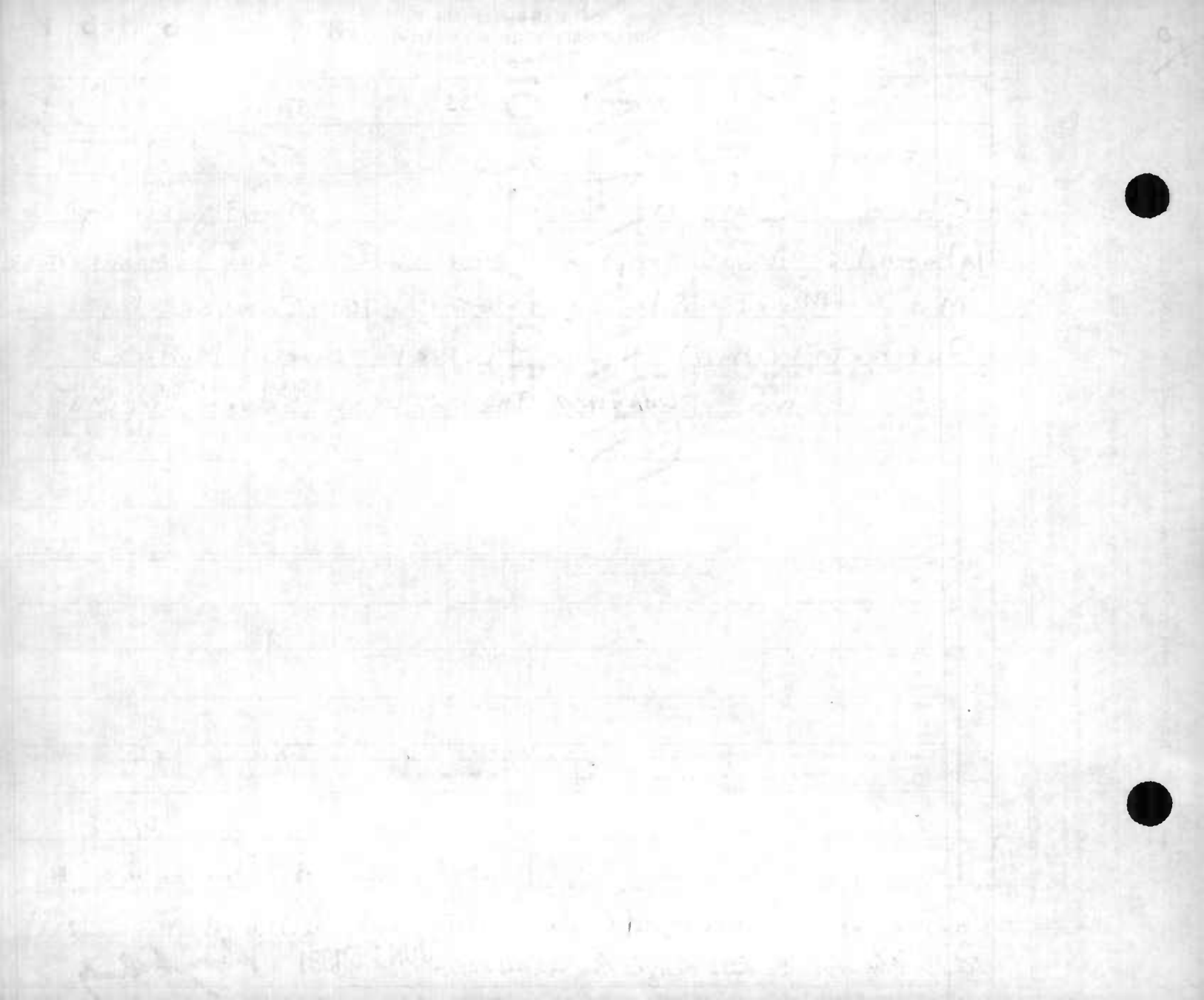
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 8116361   |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MILDRED (NMN) LISS   |  |  |  | June 11 '81 6:27 PM  |  |   |  |
| 3. SEX Female   |  | 4. RACE White  |  | 5. DATE OF BIRTH MONTH DAY YEAR 7 13 24  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio  |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.   |  |
| 10. CITY OR TOWN OF DEATH Takoma Park   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washinnylon Adventist |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary  |  | 12b. KIND OF BUSINESS OR INDUSTRY MANUFACTURE   |  |
| 13a. STATE Md 13b. COUNTY Monty 13c. CITY OR TOWN S.I. Spg  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Garnett (NMN) Pollock   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mabel (NMN) Miller  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No  |  |  |  | 16b. SOCIAL SECURITY NO. unknown   |  |   |  |
| 17. INFORMANT ADDRESS Thedone Liss 1314 Canyon Dr Silver Spg Md   |  |  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARCINOMA OF LUNG<br>1629<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/7, 19 81, to 6/11, 19 81, that (I) (we) lost saw the deceased alive on 6/11, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |   |  |
| 22b. SIGNATURE M.D. C. Brance   |  |  |  | DEGREE MD  |  | 22c. DATE SIGNED 6/11/81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kierland C. Brance  |  |  |  | 22e. ADDRESS 4600 Carroll Ave Takoma Park, Md  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation   |  | 23b. DATE June 13 1981   |  | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE PG-Md   |  |
| 24. FUNERAL DIRECTOR W. W. Chambers Co 8655 Georgia Ave, S.S. Md 20910  |  |  |  | DATE RECEIVED BY REGISTRAR JUN 15 1981 REGISTRAR'S SIGNATURE [Signature]   |  |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR<br>STATE<br>REGISTRAR  |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                      |  |  |  | 8 1 1 6 3 6 2   |  |  |  |
|--|--|--|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  |  | 2a. DATE OF DEATH   |  |  |  | 3. SEX  |  |  |  |
| Marie W. Littleton   |  |  |  | 6/4/81  |  |  |  | Female  |  |  |  |
| 3. SEX   |  |  |  | 4. RACE   |  |  |  | 5. DATE OF BIRTH  |  |  |  |
| Female   |  |  |  | White   |  |  |  | May 28, 1893  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |
| North Carolina   |  |  |  | U.S.A.  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  |  |
| Chevy Chase  |  |  |  | Bethesda Nursing & Retirement Ctr.  |  |  |  | Ret.-Secretary  |  |  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  | 13a. STREET ADDRESS   |  |  |  | 13b. CITY OR TOWN   |  |  |  |
| Secretarial  |  |  |  | 8700 Jones Mill Road  |  |  |  | Chevy Chase   |  |  |  |
| 14. FATHER'S NAME  |  |  |  | 15. MOTHER'S MAIDEN NAME  |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |  |  |
| George L. Womble   |  |  |  | Ava G. Gattis   |  |  |  | No  |  |  |  |
| 16b. SOCIAL SECURITY NO.   |  |  |  | 17. INFORMANT   |  |  |  | 18. ADDRESS   |  |  |  |
| 578-66-6165  |  |  |  | Thomas M. Gittings  |  |  |  | 806-15th St., NW, Wash., D.C.   |  |  |  |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u><br><u>4140</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>arteriosclerotic heart disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Generalized arteriosclerosis</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>2 mo</u><br><u>10 yrs</u> |  |  |  |   |  |  |  |   |  | 20. DATE OF OPERATION  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |   |  |  |  |   |  | 21a. DATE OF OPERATION   |  |
| 21b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |   |  |  |  |   |  | 22a. AUTOPSY?  |  |
| 22b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?   |  |  |  |   |  |  |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |  |
| 23a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  |   |  |  |  |   |  | 24a. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |
| 25a. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |   |  |  |  |   |  | 26a. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                      |  |
| 27a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  |  |  |   |  |  |  |   |  | 28a. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |
| 29a. I certify that (I) (the hospital) attended the deceased from <u>2/11</u> , 19 <u>75</u> , to <u>6/6</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>6/1</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |   |  | 30a. SIGNATURE   |  |
| 31a. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  |   |  |  |  |   |  | 32a. ADDRESS   |  |
| Stephen W. Nealon, Jr.   |  |  |  |   |  |  |  |   |  | 916 - 19th Street, N.W., Washington, D.C.                              |  |
| 33a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  |  |   |  |  |  |   |  | 34a. DATE  |  |
| Entombment   |  |  |  |   |  |  |  |   |  | 6/9/81   |  |
| 35a. NAME OF CEMETERY OR CREMATORY   |  |  |  |   |  |  |  |   |  | 36a. LOCATION<br>CITY OR TOWN COUNTY STATE                             |  |
| Ft. Lincoln Mausoleum  |  |  |  |   |  |  |  |   |  | Brentwood, Maryland  |  |
| 37a. FUNERAL DIRECTOR  |  |  |  |   |  |  |  |   |  | 38a. DATE REC'D. BY REGISTRAR  |  |
| Joseph Gawler's Sons, Inc.   |  |  |  |   |  |  |  |   |  | JUN 10 1981  |  |
| 5130 Wisconsin Ave., NW, Washington, D.C. 20016  |  |  |  |   |  |  |  |   |  | 39a. REGISTRAR'S SIGNATURE   |  |
|  |  |  |  |   |  |  |  |   |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 833-2673.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO. 8116363   |  |  |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST MIDDLE LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  | 2b. HOUR   |  |  |  |
| MARCELLA OTHELIA LLOYD   |  |  |  | JUNE 15, 1981  |  | 2:20 <sup>P</sup>  |  | M  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.  |  |
| FEMALE   |  | WHITE  |  | AUGUST 19, 1920  |  | 60 YRS.  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |  |
| Virginia   |  | U.S.A.   |  |  |  | MONTGOMERY COUNTY MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| BETHESDA   |  | THE CLINICAL CENTER  |  |  |  | Housewife  |  | Home   |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS  |  |
| VIRGINIA   |  | Shenandoah   |  | QUICKSBURG   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                          |  | RT1, BOX 30 (22847)  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  |  |  |  |  |
| Luther B. Funkhouser   |  | Lizzie Rozella Funkhouser  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS  |  |  |  |
| No   |  | 231-54-8411  |  | MR. THOMAS LLOYD   |  | SAME AS ABOVE  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |  |  |  |  |
| PART 1. DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a) Cardiopulmonary arrest   |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Diffuse Histiocytic Lymphoma  |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |  |  |  |  |  |
| MEDICAL CERTIFICATION  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from JUNE 12, 1981, to JUNE 15, 1981, that (I) (we) lost saw the deceased alive on JUNE 15, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE   |  | DEGREE   |  |  |  | 22c. DATE SIGNED   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |  |  |  |  |  |  |
| Gregory A. Curt  |  | NATIONAL INSTITUTES OF HEALTH CLINICAL CENTER, BETHESDA, MARYLAND 20205                                |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |  |  |
| Burial   |  | 6/18/81  |  | Mt. Jackson Cem.   |  | Mt. Jackson, Va.   |  |  |  |
| 24. FUNERAL DIRECTOR NAME  |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |
| Capitol Funeral Service, Fairfax, Va.  |  |  |  | JUN 19 1981  |  |  |  |  |  |



RECEIVED



U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |               |   |   |  |  |   |   |   | REG. NO. 16364   |  |
|---|--|---------------|---|---|--|--|---|---|---|--|--|
| 1. FOR STATE REGISTRAR  |  |               |   |   |  |  |   |   |   | 20. DATE KNOWN OF DEATH  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GRACIANA LOURIDO   |  |               |   |   |  |  |   |   |   | 20. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 06 14 81                        |  |
| 2. SEX Female   |  | 4. RACE White |   | 5. DATE OF BIRTH MONTH DAY YEAR 05 03 03                    |  | 6. AGE (IN YEARS) (LAST BIRTHDAY) 78 YRS.  |   | IF UNDER 24 HRS. MONTHS DAYS HOURS MIN  |   | 21. DATE PRONOUNCED DEAD MONTH DAY YEAR 06 14 81                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Uruguay   |  |               | 7b. CITIZEN OF WHAT COUNTRY? Uruguay  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |   | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD          |  |  |
| 10. CITY OR TOWN OF DEATH Bethesda  |  |               | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None   |   |   | 12b. KIND OF BUSINESS OR INDUSTRY None                      |  |  |
| 13a. STATE Maryland   |  |               | 13b. COUNTY Montgomery  |   | 13c. CITY OR TOWN Bethesda                                     |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 13a. STREET ADDRESS 5501 Kirkwood Drive                     |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Alfonso - Pissarella  |  |               |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Garciana - Martinez |  |   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No   |  |               | 16b. SOCIAL SECURITY NO. N/A  |   |  | 17. INFORMANT ADDRESS Juan Carlos Lourido-Address same as #13.   |   |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Rupture Abdominal Aneurysm</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. <u>Cardio-Vascular Disease</u><br>(b) <u>Cardio-Vascular Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |               |   |   |  |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.   |  |               |   |   |  |  |   |   |   |  |  |
| 19a. DATE OF OPERATION  |  |               |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |  |   |   |   | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |               |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19        |  |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |               |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  |  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |   |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |               |   |   |  |  |   |   |   |  |  |
| ACTUAL SIGNATURE John G. Ball   |  |               |   | TITLE (SPECIFY) M.D. DePUTY                                 |  |  |   | DATE SIGNED June 14, 1981   |   |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) John G. Ball, M.D.  |  |               |   | ADDRESS 7936 Old Georgetown Road Bethesda, Maryland 20014   |  |  |   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial/Transit  |  |               |   | 23b. DATE 6/16/81   |  | 23c. NAME OF CEMETERY OR CREMATORY Buco Cemetery   |   |   | 23d. LOCATION CITY OR TOWN COUNTY STATE Montevideo, Uruguay |  |  |
| 24. FUNERAL DIRECTOR NAME Jos. Gawler's Sons, Inc.  |  |               |   |   |  | ADDRESS -5130 Wisc. Ave, NW-Wash, DC   |   |   | 25a. DATE REC'D. BY REGISTRAR JUN 15 1981                   |  |  |
|   |  |               |   |   |  |  |   |   | 25b. REGISTRAR'S SIGNATURE [Signature]                      |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |  |   |  |  |   |  |
|--|--|---|--|--|---|--|--|---|--|
| 1 - FOR STATE REGISTRAR  |  |   |  |  | REG. NO.  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>HELEN M LOY</b>  |  |   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>JUNE 26, 1981</b>             |  |  | 2b. HOUR <b>3<sup>35</sup> PM</b>   |  |
| 3. SEX <b>Female</b>   |  | 4. RACE <b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>10 30 02</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 1 HRS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.                                   |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>Silver Spring</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b> |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housemother</b>             |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>School for Deaf</b>  |  |
| 13a. STATE <b>Maryland</b>   |  | 13b. COUNTY <b>Montgomery</b>   |  | 13c. CITY OR TOWN <b>Silver Spring</b>   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>1532 Red Wood Drive</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Gideon O. Harne</b>   |  |   |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Alta L. Redmond</b> |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>  |  | 16b. SOCIAL SECURITY NO. <b>213 24 8428</b>   |  | 17. INFORMANT ADDRESS <b>Silver Spring, Md. Ernest G. Loy, 1532 Red Wood Drive,</b>  |   |  |  |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br><b>2773</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cardiac shock</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Myocardial infarction</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THEIR CRIMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Arteriosclerosis cardiovascular disease</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Recent</b><br><b>Arteriosclerosis</b><br><b>NIS</b> |  |   |  |  |   |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |   | 19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)   |   |  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET   |   | CITY OR TOWN   |  | COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>June 21, 1981</b> to <b>June 26, 1981</b> , that (I) (we) last saw the deceased alive on <b>June 26, 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |   |  |  |   |  |
| 22b. SIGNATURE <b>Albert H. Grollman MD</b>  |  |   |  | DEGREE   |   |  |  | 22c. DATE SIGNED <b>6/26/81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ALBERT H. GROLLMAN, MD.</b>   |  |   |  | 22e. ADDRESS <b>1106 Spring St. Silver Spring, Md.</b>   |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  | 23b. DATE <b>June 30, 1981</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>  |   | 23d. LOCATION CITY OR TOWN <b>Frederick</b> COUNTY <b>Brederick</b> STATE <b>Md.</b>         |  |   |  |
| 24. FUNERAL DIRECTOR'S NAME (TYPE OR PRINT) <b>Smith, Padeley, Keeney &amp; Basford Funeral Home</b>   |  |   |  | 25a. DATE REC'D BY REGISTRAR <b>JUL 1 1981</b>   |   |  |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>   |  |
| 106 East Church Street, Frederick, Maryland  |  |   |  |  |   |  |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |   |  |  |  |  |   |  |
|---|--|--|--|---|--|--|--|--|---|--|
| CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |  |   |  |
| 1. FOR STATE REGISTRAR  |  |  |  |   | REG. NO.   |  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Robert Lee LUCADO</b>   |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>6/18/81</b>   |  |  | 2b. HOUR<br><b>7:00 A</b>                                  |   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>CAUC.</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>MAY 6 1901</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS.                                      |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN. |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Va.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                          |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rockville</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SHADY GROVE Adventist Hosp.</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Security Guard</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Security</b>       |   |  |
| 13a. STATE<br><b>Maryland</b>   |  |  |  |   | 13b. COUNTY<br><b>Mont.</b>  |  | 13c. CITY OR TOWN<br><b>Rockville</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Unknown</b>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Unknown</b>   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>yes</b>   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br><b>Unknown</b>   |  | 17. INFORMANT<br><b>Homer Lucado</b>  |  | ADDRESS<br><b>Gaithersburg, Md. 20760</b>  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOGENIC SHOCK</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>MALACED AT INFORMATION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ATHEROSCLEROSIS</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |  |  |  |   |  |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 DAYS</b><br><b>30 DAYS</b><br><b>?</b>   |  |  |  |   |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>CEREBRO VASCULAR ACCIDENT - NEUROCOMA</b>  |  |  |  |   |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6/15</b> 19 <b>81</b> to <b>6/18</b> 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>6/15</b> 19 <b>81</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |  |   |  |
| 22b. SIGNATURE <b>[Signature]</b> DEGREE  |  |  |  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  | 22c. DATE SIGNED<br><b>6/18/81</b>                         |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GREGARIO KAPP</b>   |  |  |  |   | 22e. ADDRESS<br><b>RT DEER PARK DR. GAITHERSBURG MD</b>  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>June 20, 1981</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Norbeck Mem. Park</b>  |  | 23d. LOCATION CITY OR TOWN<br><b>Olney</b>   |  | COUNTY<br><b>Mont.</b> STATE<br><b>Md.</b>                 |   |  |
| 24. FUNERAL DIRECTOR<br><b>FRANCIS H. BARBER LAYTONSVILLE, MD. 20760</b>  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 22 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| FOR<br>1 - STATE<br>REGISTRAR   |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 1 1 6 3 6 7<br>REG. NO.  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ELSE</b>  |  |  |  | FIRST MIDDLE LAST<br><b>LUTZE</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>6 3 81</b>  |  |  |  | 2b. HOUR<br><b>4 P M</b>                         |  |
| 3 SEX<br><b>Female</b>  |  |  |  | 4 RACE<br><b>White</b>   |  | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>Sept. 20, 1903</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.   |  | # UNDER 1 YEAR<br>MONTHS DAYS  |  | # UNDER 24 HRS<br>HOURS MIN                      |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Germany</b>  |  |  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>Germany</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.   |  |  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Bethesda</b>   |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>5732 Bradley Blvd.</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>   |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b> |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br><b>W. Germany</b>   |  |  |  | 13b. COUNTY<br><b>Unknown</b>  |  | 13c. CITY OR TOWN<br><b>Hannover</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>37 Ostfeldstrasse</b>  |  |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Leberecht Steppuhn</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Auguste Gulweid</b>  |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |  |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><b>None</b>  |  | 17 INFORMANT ADDRESS<br><b>Roswita Heyken-5732 Bradley Blvd. Beth. Md.</b>   |  |  |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>acute myocardial infarction -</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>acute insufficiency -</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>due to, or as a consequence of</b><br>(c) <b>metastatic cancer of breast</b> |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/30</b> , 19 <b>81</b> , to <b>5/30</b> , 19 <b>81</b> , that (I) (we) lost<br>saw the deceased alive on <b>5/30</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Werner Prinz, M.D.</b>   |  |  |  | DEGREE<br><b>M.D.</b>  |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>6/3/81</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Werner Prinz, M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>3213 Columbia Pike Arl., Va. 22204</b>  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Removal-Burial</b>   |  |  |  | 23b. DATE<br><b>6/5/81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Engesohder Friedhof</b>   |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Hannover, West Germany</b>  |  |  |  |
| 24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b><br>NAME ADDRESS<br><b>5130 Wisc. Ave. N.W. Wash., D.C.</b>   |  |  |  |  |  | 25. DATE REC'D. BY REGISTRAR<br><b>JUN 4 - 1981</b>  |  | 25b. SIGNATURE<br><b>[Signature]</b>   |  |  |  |  |  |

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APPROVAL OF TITLE MEDICAL EXAMINER  
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |   |  | REG. NO.   |  |
|---|--|---|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 1. DECEASED NAME (TYPE OR PRINT)  |  |   |  | 2a. DATE OF DEATH  |  |   |  | 2b. HOUR   |  |
|   |  | John J. Madden, Sr.   |  |   |  | 06 03 81   |  |   |  | 202 P  |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS  |  |
| Male  |  | White   |  | 09 07 22  |  | 58 YRS.  |  | MONTHS DAYS   |  | HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |  |  |
| Pennsylvania  |  | U.S.A.  |  |   |  | Montgomery MD  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| Bethesda  |  | Suburban Hospital   |  |   |  | Assurance Spec.  |  | Vet. Admin.   |  |  |  |
| 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS   |  |  |  |
| Maryland  |  | Montgomery  |  | Bethesda  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 5528 Westband Avenue  |  |  |  |
| 14. FATHER'S NAME   |  |   |  | 15. MOTHER'S MAIDEN NAME  |  |  |  |   |  |  |  |
| Joseph - Madden   |  |   |  | Bridgett - Tierney  |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS  |  |   |  |  |  |
| Yes   |  |   |  | W.W. II   |  | 179-14-4805 Clare H. Madden - Address same as #13 above.                       |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4413 ruptured abdominal aneurysm<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>12 hours       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>Hypertension  |  |   |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |   |  |   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-3 1981, to 6-3 1981, that (I) (we) lost saw the deceased alive on 6-3 1981 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE  |  |   |  | DEGREE  |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/><br>PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED   |  |
| WILLIAM E. HURWITZ  |  |   |  | 5120 MACARTHUR BLVD NW WASH DC  |  |  |  |   |  | 6-3-81   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |  |  |
| Burial  |  |   |  | June 6, 1981  |  | Gate of Heaven Cem.  |  | Silver Spring-Montgomery-Md.  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME  |  |   |  | 25a. DATE REC'D. BY REGISTRAR   |  |  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |
| Jos. Gawler's Sons, Inc. 5130 Wisc. Ave, N.W.-Wash, D.C.  |  |   |  | JUN 10 1981   |  |  |  | Rickey McBrady  |  |  |  |





## CERTIFICATE OF DEATH

REG. NO.

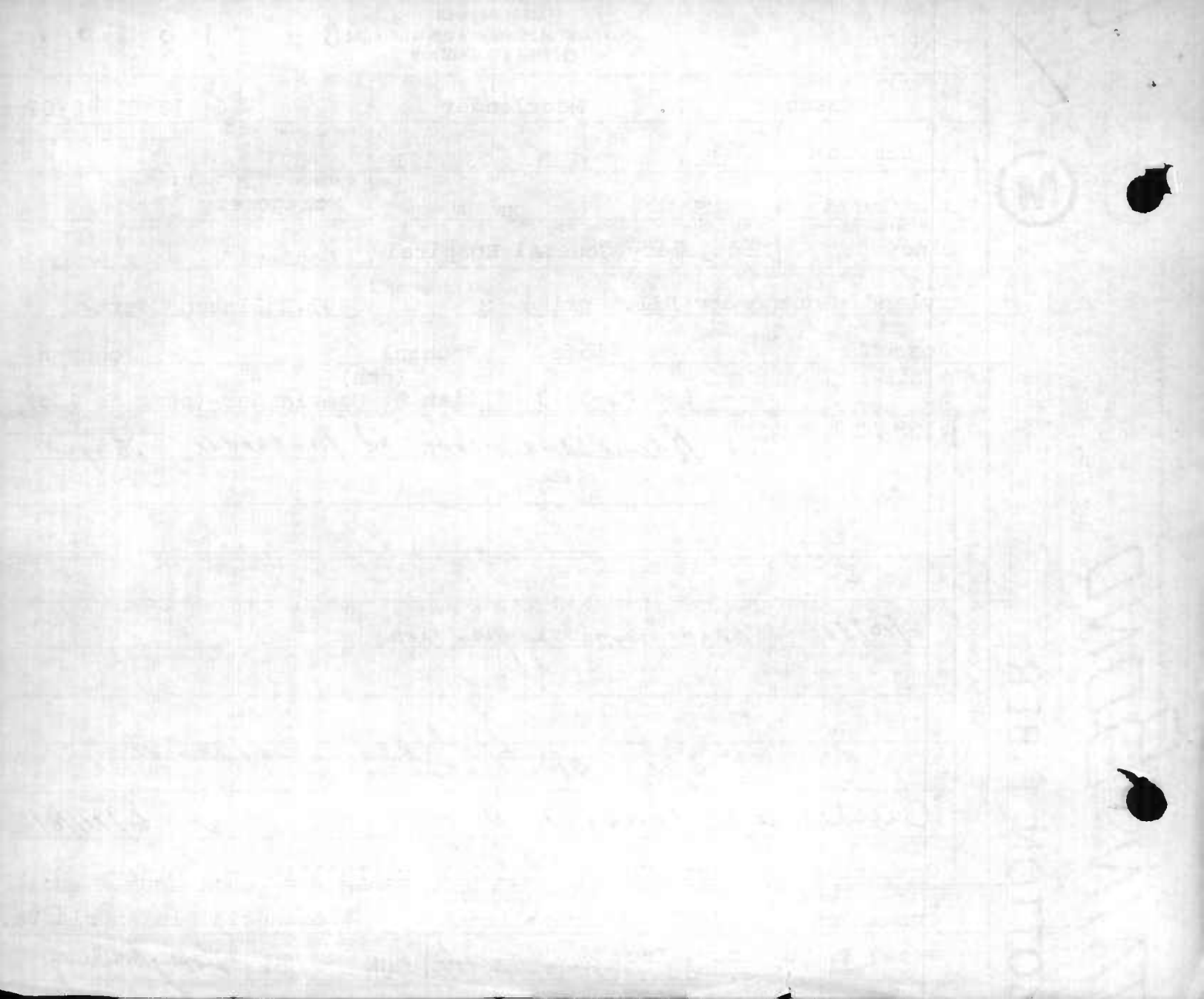
1. FOR  
STATE  
REGISTRAR

|  |  |   |  |   |                           |  |  |
|--|--|---|--|---|---------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Marie K. Maerlender</b>   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>6 13 81</b> |   | 2b. HOUR<br><b>8:07pm</b> |  |  |
| 3. SEX<br><b>female</b>  |  | 4. RACE<br><b>white</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Feb. 23 1912</b>   |                           | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS   |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                           | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Olney</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Montgomery General Hospital</b>                           |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>  |                           | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>own home</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Montgomery</b>  |  | 13c. CITY OR TOWN<br><b>Sil. Spring</b>   |                           | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph Kiefe</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rachael Johnson</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>no</b>  |                           |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>135-03-3023</b>   |  | 17. INFORMANT (son) ADDRESS<br><b>William H. Maerlender-(same as 13e)</b>   |  |   |                           |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Adenocarcinoma of Pancreas</b><br>1579<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 yrs</b> |  |   |  |   |                           |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>---</b>   |  |   |  |   |                           |  |  |
| 19a. DATE OF OPERATION<br><b>6/10/81</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>carcinoma of pancreas</b>  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                           | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                           |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                           |  |  |
| 22a. I certify that (H) (this hospital) attended the deceased from <b>6/11 1981</b> to <b>6/13 1981</b> , that (I) (we) lost<br>saw the deceased alive on <b>6/13 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |                           |  |  |
| 22b. SIGNATURE<br><b>Catherine M. Chura, M.D.</b>  |  | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>6/14/81</b>  |                           |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Catherine M. Chura, MD</b>   |  | 22e. ADDRESS<br><b>18111 Pr. Phillip Dr., Olney, Md.</b>  |  |   |                           |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   |  | 23b. DATE<br><b>6-15-81</b>   |  | 23c. NAME OF CEMETERY<br><b>Metropolitan</b>  |                           | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Alexandria Alexandria Va.</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>Warner E. Pumphrey, Inc.</b><br><b>8434 Ga. Ave., S.S. Md.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 13 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Howard Hale</b>  |                           |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |  |  |   |  |  |  | 8 1 1 6 3 7 0                                |  |
|--|--|--|--|--|--|---|--|--|--|--|--|
| FOR<br>1 - STATE<br>REGISTRAR  |  |  |  |  |  |   |  |  |  | CERTIFICATE OF DEATH                         |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  |  |  |   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR             |  |
| FIRST JULIA MIDDLE L. LAST MALAMUT<br><i>Julia L. Malamut</i>  |  |  |  |  |  |   |  |  |  | 6-27-81                                      |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR MONTHS DAYS                                    |  | IF UNDER 24 HRS. HOURS MIN.                  |  |
| FEMALE   |  | WHITE  |  | JULY 18 1912   |  | 68  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |  |  |
| WASHINGTON, DC   |  | U.S.A.   |  |  |  | Montgomery County MD.   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NURSING HOME, GIVE STREET ADDRESS)   |  |  |  | 12a. USUAL OCCUPATION (TYPE OR WORK OR BUSINESS WORKING (IF))       |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |  |  |
| Silver Spring  |  | Holy Cross Hosp.   |  |  |  | SECRETARY   |  | US GOVERNMENT  |  |  |  |
| 13a. STATE   |  |  |  |  |  |   |  |  |  | 13b. CITY OR TOWN                            |  |
| MARYLAND PR. GEORGES   |  |  |  |  |  |   |  |  |  | ADELPHI                                      |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  |  |  |  |  |   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |
| ABRAHAM LEVY   |  |  |  |  |  |   |  |  |  | BESSIE LEVY                                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMATION ADDRESS  |  |   |  |  |  |  |  |
| NO   |  | 213-54-6159  |  | IRVING MALAMUT, same as #13  |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:   |  |  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| IMMEDIATE CAUSE (a) <i>pneumonia, asphyxiation</i>   |  |  |  |  |  |   |  |  |  | 1 day  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>cerebral hemorrhage</i>  |  |  |  |  |  |   |  |  |  | 1 day  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i>coronary insufficiency</i>   |  |  |  |  |  |   |  |  |  | 1 day  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |  |  |  |  |   |  |  |  |  |  |
| <i>decubitus ulcer, paraplegia</i>   |  |  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |  |
|  |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |  |  |  |  |
|  |  | P.M. 19  |  |  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET   |  | CITY OR TOWN  |  | COUNTY   |  | STATE  |  |
|  |  |  |  |  |  |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>July</i> , 19 <i>68</i> , to <i>6/27</i> , 19 <i>81</i> , that (I) (we) last saw the deceased alive on <i>6/26</i> , 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE   |  | DEGREE   |  |  |  | 22c. DATE SIGNED  |  |  |  |  |  |
| <i>Israel Spector MD</i>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |  | 6/27/81   |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |  |  |   |  |  |  |  |  |
| Israel Spector MD  |  | 12001 Fenara Ave   |  |  |  | Wheaton Md 20906  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  |  |  |  |  |
| BURIAL   |  | 6/29/1981  |  | SOUTHEAST HEBREW CONGREGATION CEMETERY   |  | WASHINGTON  |  | D. C.  |  |  |  |
| 24. FUNERAL HOME   |  |  |  |  |  |   |  |  |  | DATE REC'D BY REGISTRAR                      |  |
| DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME   |  |  |  |  |  |   |  |  |  | JUL 1 1981                                   |  |
| 232 CARROLL STREET, N. W., WASHINGTON, D. C.   |  |  |  |  |  |   |  |  |  |  |  |

BP



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3205

BP

NO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

NO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |   |                               |  |
|--|--|--|---|---|-------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>First: <u>Malone</u> Middle: <u>Stephen E.</u> Last: <u>Maloney</u>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><u>6</u> <u>22</u> <u>81</u> |   | 2b. HOUR<br>A. <u>6:50</u> M. |  |
| 3. SEX<br><u>Male</u>  |  | 4. RACE<br><u>White</u>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><u>10</u> <u>24</u> <u>07</u>                 |                               |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>73</u> YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><u>73</u>   |   | 8. IF UNDER 24 HRS<br>HOURS MIN.<br><u>6:50</u>                                     |                               |  |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>Alabama</u>  |  | 9b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |   | 10. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Montgomery</u> MD.                      |                               |  |
| 11. CITY OR TOWN OF DEATH<br><u>Rockville</u>  |  | 12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>Cobbinswood Nursing Center</u> |   | 13. USUAL OCCUPATION<br>(TYPE OF WORK FOR MAINTENANCE OF LIFE)<br><u>Bricklayer</u> |                               |  |
| 14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>14a. STATE <u>Maryland</u> 14b. COUNTY <u>Montgomery</u> 14c. CITY OR TOWN <u>Silver Spring</u>   |  | 15. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>                                      |   | 16. STREET ADDRESS<br><u>1613 Wood Well, Rd.</u> <u>20906</u>                       |                               |  |
| 17. FATHER'S NAME<br>First: <u>Richard</u> Middle: <u>M.</u> Last: <u>Maloney</u>  |  | 18. MOTHER'S MAIDEN NAME<br>First: <u>Effie</u> Middle: <u>Jenkins</u> Last: <u>Jenkins</u>  |   | 19. ADDRESS<br><u>Phyllis Maloney/Wife/ Same as 13c</u>                             |                               |  |
| 20. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <u>No</u>  |  | 21. SOCIAL SECURITY NO.<br><u>444-09-4288</u>  |   | 22. INFORMANT<br><u>Phyllis Maloney/Wife/ Same as 13c</u>                           |                               |  |
| 23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Neumonia, Respiratory</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>4860</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Neumonia, Respiratory</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |   |   |                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |   |   |                               |  |
| 24. DATE OF OPERATION<br><u>June 21, 1981</u>  |  | 25. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>Neumonia, Respiratory</u>  |   | 26. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |                               |  |
| 27. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 28. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><u>19</u>  |   | 29. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |                               |  |
| 30. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 31. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 32. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                               |  |
| 33. I certify that (I) (this hospital) attended the deceased from <u>June 21, 1981</u> to <u>June 21, 1981</u> , that (I) (we) lost saw the deceased alive on <u>June 21, 1981</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not (aid) and not view the body after death)   |  |  |   |   |                               |  |
| 34. SIGNATURE<br><u>Dr. Thomas Dooley</u> DEGREE   |  |  |   | 35. DATE SIGNED<br><u>June 22, 1981</u>   |                               |  |
| 36. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Dr. Thomas Dooley</u>   |  |  |   | 37. ADDRESS<br><u>2901 Olney, Sandy Spring, Md.</u>                                 |                               |  |
| 38. BURIAL, CREMATION, REMOVAL<br>(Specify)<br><u>Cremation</u>  |  | 39. DATE<br><u>June 22, 1981</u>   |   | 40. NAME OF CEMETERY OR CREMATORY<br><u>Lee's Crematory</u>                         |                               |  |
| 41. FUNERAL DIRECTOR<br><u>Hines/Rinaldi F.H.</u>  |  | 42. ADDRESS<br><u>11800 New Hampshire Ave Silver Spring, Md. 20904</u>   |   | 43. DATE REC'D. BY REGISTRAR<br><u>JUN 30 1981</u>                                  |                               |  |
| 44. REGISTRAR'S SIGNATURE  |  | 45. REGISTRAR'S SIGNATURE  |   |   |                               |  |

MEDICAL CERTIFICATION





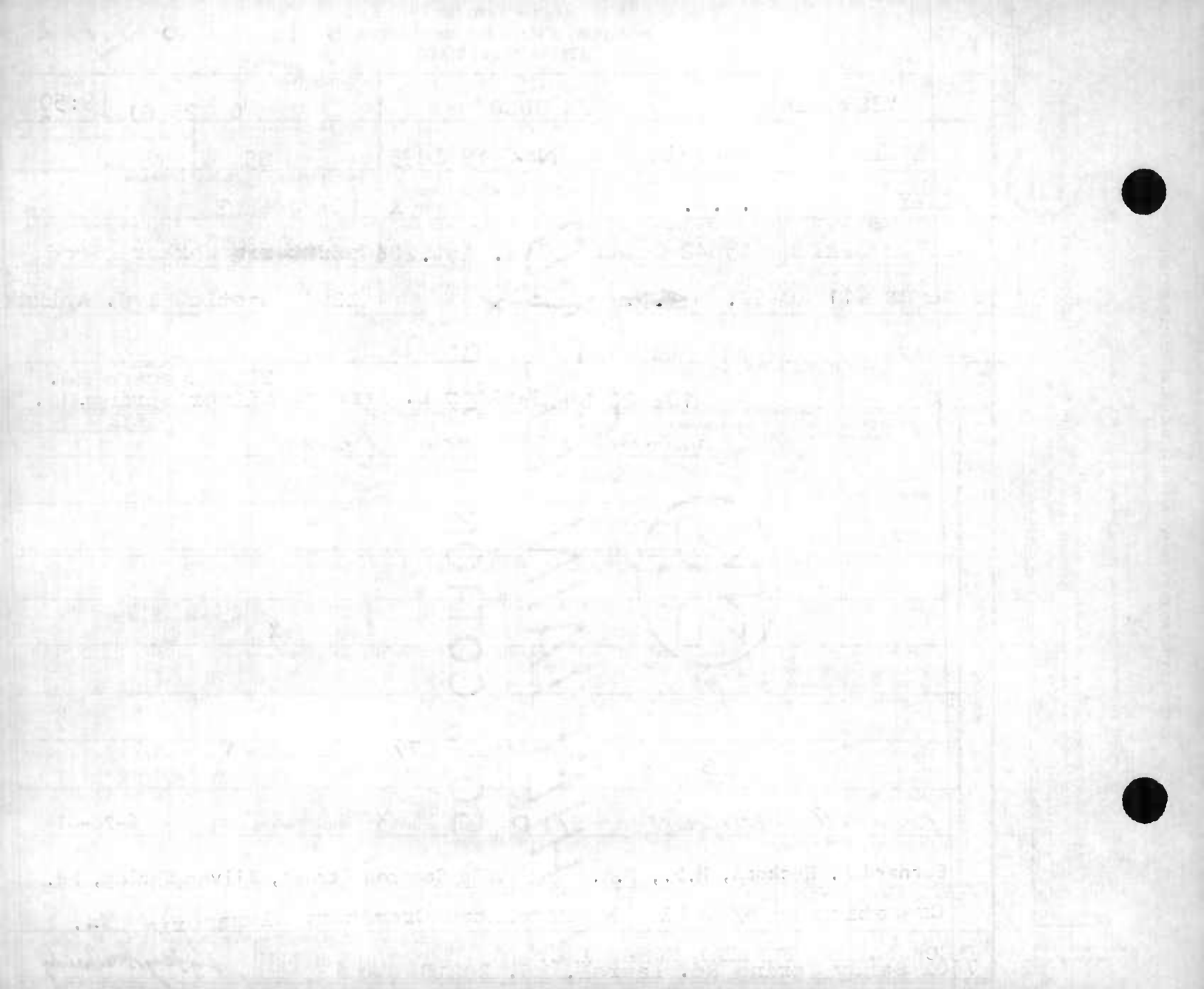
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 6 3 7 2

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |   |   |  |   |   |   |  |  |
|--|--|---|---|---|---|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>VICTORIA</b>  |  |   | 2a. DATE OF DEATH<br>MONTH <b>6</b> DAY <b>25</b> YEAR <b>81</b>  |   |   | 2b. HOUR<br><b>9:50</b> AM   |   |   |   |  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>Caucasian</b>                   |   | 5. DATE OF BIRTH<br>MONTH <b>Nov.</b> DAY <b>19</b> YEAR <b>1895</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b> YRS.  |   | 7. IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b> |   | 7. IF UNDER 24 HRS<br>HOURS <b></b> MIN. <b></b>           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>ITALY</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.  |   |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>SILVER SPRING</b>  |  |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>13842 Castle Blvd. Apt. 204</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Caffateria Worker</b>   |   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Food</b>  |  |  |
| 13a. STATE<br><b>same as #11</b>   |  |   | 13b. COUNTY<br><b>MONTG.</b>  |   | 13c. CITY OR TOWN<br><b>SILVER SPRING</b> |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>13842 Castle Blvd. Apt. 204</b>   |  |  |
| 14. FATHER'S NAME<br>FIRST <b>FELICE</b> MIDDLE <b></b> LAST <b>GIUFFRA</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>ANTONIA</b> MIDDLE <b></b> LAST <b>CROCCO</b>  |   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>   |   |   |   |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>102 20 0954</b>   |  |   | 17. INFORMANT<br>ADDRESS <b>2014 Cascade Rd. Silver Spring, Md.</b>   |   |   |  |   |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>metastatic adenocarcinoma of colon</b><br><b>1539</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b></b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b>  |  |   |   |   |   |  |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b></b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b></b>   |  |   |   |   |   |  |   |   |   |  |  |
| 19a. DATE OF OPERATION<br><b>12-14</b>   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>12-14</b>  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |   |  |  |
| 22a. I certify that (I) (his hospital) attended the deceased from <b>12-14</b> , 19 <b>79</b> , to <b>6-25</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>5-28</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |   |   |  |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Bernard A. Heckman</b>  |  |   | DEGREE<br><b>M.D.</b>   |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   | 22c. DATE SIGNED<br><b>6-26-81</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Bernard A. Heckman, M.D., P.A.</b>   |  |   | 22e. ADDRESS<br><b>8830 Cameron Street, Silver Spring, Md.</b>  |   |   |  |   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   |  |   | 23b. DATE<br><b>6/26/81</b>   |   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Metropolitan Crematory Alexandria, Va.</b>  |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |  |
| 24. FUNERAL DIRECTOR<br><b>ELECK LAUREL FUNERAL HOME, INC.</b>   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 30 1981</b>   |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Johny K. Brady</b>  |   |   |   |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 1 1 6 3 7 3   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Ruth Dreichlinger Mandle   |  |   |  | 2a. DATE OF DEATH<br>June 23, 1981  |  | 2b. HOUR<br>M  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>July 4, 1898  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Denver, Colo.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Silver Spring   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Chevy Chase Nursing Home |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home  |  |
| 13a. STATE<br>Maryland   |  |   |  | 13b. CITY OR TOWN<br>Silver Sp., Md.  |  | 13c. STREET ADDRESS<br>10105 Forest Grove Dr. Sil. Sp., Md. 20902  |  |
| 14. FATHER'S NAME<br>Isaac Dreichlinger  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>Belle Kahn  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>None   |  | 17. INFORMANT<br>William Dee Mandle-son Silver Sp., Md. 20902   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a).<br>4340 Terminal cerebral thrombosis<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>years   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1980 to June 1981, that (I) (we) lost<br>saw the deceased alive on 6/22/81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>MD   |  |   |  | DEGREE<br>MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>     |  | 22c. DATE SIGNED<br>6/23/81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>OSONT LEKAGUL, MD   |  |   |  | 22e. ADDRESS<br>7415 arlington Rd Bethesda Md   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation  |  | 23b. DATE<br>24 June 1981   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Lee's Crematory   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Washington, D.C. 20002   |  |
| 24. FUNERAL DIRECTOR<br>Lee Funeral Home-300-4th St. N.E. Wash. D.C. 20002   |  |   |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |  |

June 25, 1964

Mr. J. Edgar Hoover

25

Mr. J. Edgar Hoover

Dear Sir:

Enclosed

Very truly yours,

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## CERTIFICATE OF DEATH

REG. NO.

|  |  |   |   |  |  |  |   |
|--|--|---|---|--|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ALICE KIRKPATRICK MANN</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6-14-81</b> |  |  | 2b. HOUR<br><b>2:45 P.M.</b>   |   |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Caucasian</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>November 10, 1899</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Kentucky</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BETHESDA / MONTGOMERY, MD.</b>  |   |
| 10. CITY OR TOWN OF DEATH<br><b>BETHESDA</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SUBURBAN HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>   |   |
| 13a. STATE<br><b>MARYLAND</b>  |  |   |   | 13b. COUNTY<br><b>MONTGOMERY</b>   |  | 13c. CITY OR TOWN<br><b>BETHESDA</b>   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James Kirkpatrick</b>   |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Martha Dudley</b>  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>579-60-9207</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Apt #733 Bethesda, Maryland</b><br><b>John Wilmot Mann 4400 East-West Hwy.</b>  |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b><br><b>4360</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Hypertension</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>8 days</b><br><b>Years</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |   |  |  |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6/13</b> 19 <b>81</b> , to <b>6/14</b> 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>6/13</b> 19 <b>81</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                   |  |   |   |  |  |  |   |
| 22b. SIGNATURE<br><b>Ralph M. Coan M.D.</b>  |  |   |   | DEGREE<br><b>M.D.</b>  |  | 22c. DATE SIGNED<br><b>6/14/81</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RALPH M. COAN M.D.</b>   |  |   |   | 22e. ADDRESS<br><b>4400 EAST WEST HWY<br/>BETHESDA, Md. 20814</b>  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   |  | 23b. DATE<br><b>1981</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Metropolitan Crem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Alexandria, Virginia</b>  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland 20014</b>   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN - 3 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Ralph M. Coan</b>   |   |

CHINESE UNIVERSITY OF PETROLEUM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |   |   |
|---|--|---|--|---|--|--|--|---|---|
| 1. FOR STATE REGISTRAR  |  |   |  |   | REG. NO.   |  |  |   |   |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Prince emanuel Mark   |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>06/ 08 81  |  |  | 2b. HOUR<br>10:00aM   |   |
| 3. SEX<br>male  |  | 4. RACE<br>white  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>12/23/27   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>53 YRS                              |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN. |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pakistan   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>Pakistan  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery county MD.          |  |   |   |
| 10. CITY OR TOWN OF DEATH<br>takoma park  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Washington adventist hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>clerk |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>boma inter.              |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE md 13b. COUNTY mc 13c. CITY OR TOWN silver spring  |  |   |  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>323 south hampton dr.   |   |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Alexander Samuel   |  |   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Mercy Shrifa                                   |  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>212-92-1384   |  | 17. INFORMANT ADDRESS<br>susheila mark same   |  |  |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Acute Myocardial Infarct</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <u>Cardiogenic Shock</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) |  |   |  |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                    |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                    |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |  |  |   |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/8</u> 19 <u>81</u> to <u>6/8</u> 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>6/8</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |   |   |
| 22b. SIGNATURE<br>Gary W. Langston, M.D.  |  |   |  |   | DEGREE   |  | 22c. DATE SIGNED<br>6/8/81   |   | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Gary W. Langston, M.D. |
| 22e. ADDRESS<br>Washington Adv. Hospital  |  |   |  |   |  |  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>June 16, 1981  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Gulberg Road Cem.   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>LaHore Pakistan             |  |   |   |
| 24. FUNERAL DIRECTOR NAME<br>Hines/Rinaldi F.H./  |  | 11800 New Hampshire Ave<br>Silver Spring, Md.   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 10 1981                           |  | 25b. REGISTRAR'S SIGNATURE<br>R. Hines                        |   |



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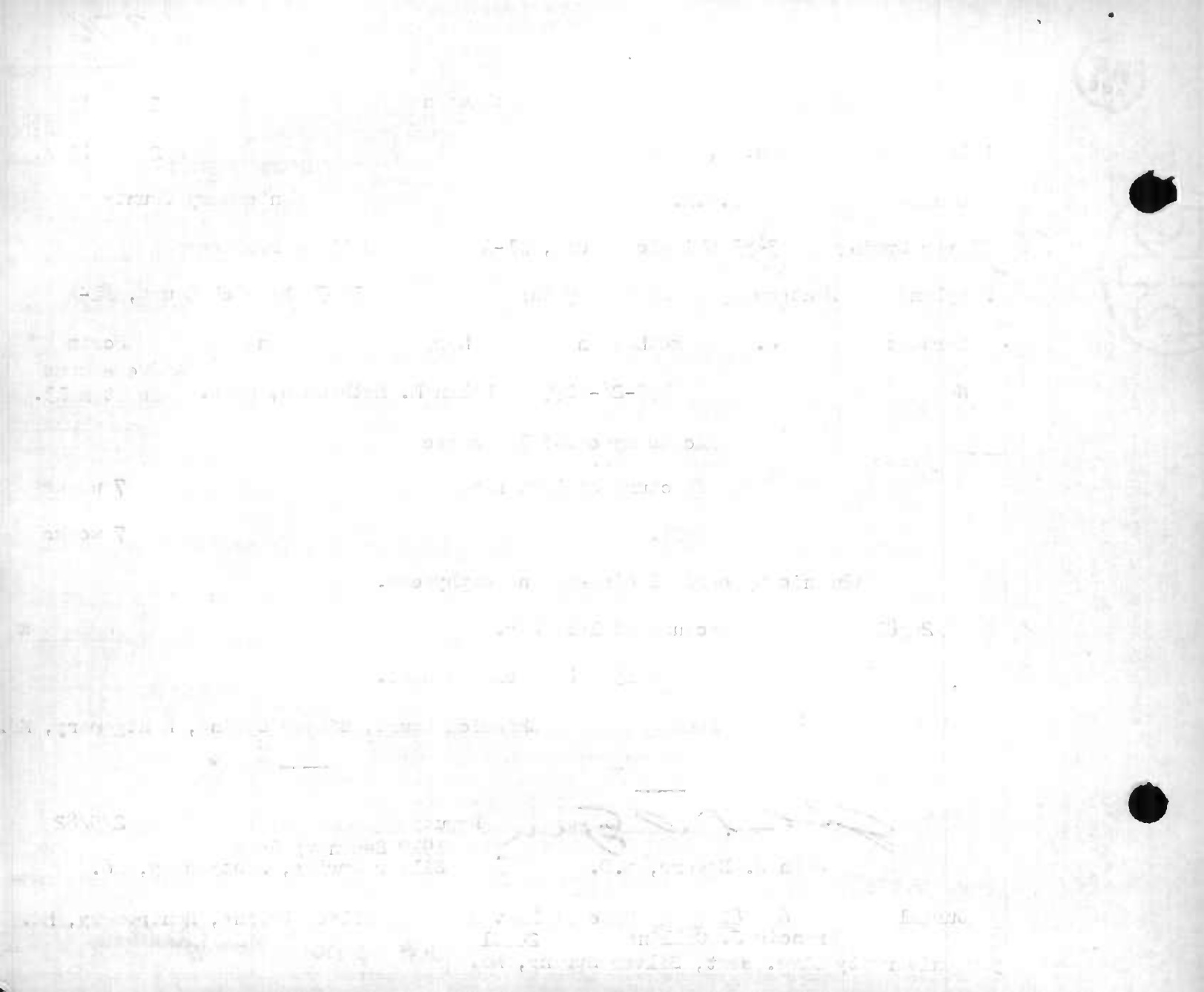
DHMH - 17  
(VR A15 ME (5))  
15M 2/80

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

81-16376  
REG. NO.

|  |         |   |                   |  |                     |   |  |  |  |
|--|---------|---|-------------------|--|---------------------|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST MIDDLE LAST   |                   | 2a. DATE KNOWN OF DEATH  |                     | MONTH DAY YEAR                          |  | 2b. HOUR   |  |
| Wilfred J. Mathewson   |         |   |                   | 6/2 19 81  |                     |   |  | M  |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH  | 6. AGE (IN YEARS) | 7. IF UNDER 1 YR.  | 8. IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD                |  | 4. HOUR  |  |
| Male   | White   | Jan. 4, 1897  | 84 YRS.           |  |                     | 6/2 19 81                               |  | A. M   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?  |                   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                     | 9. BALTIMORE CITY OR COUNTY OF DEATH    |  |  |  |
| Canada   |         | U.S.A.  |                   |  |                     | Montgomery County MD.                   |  |  |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |                     | 12b. KIND OF BUSINESS OR INDUSTRY       |  |  |  |
| Silver Spring  |         | 3453 Chiswick Court, #1-A   |                   | College Professor  |                     |   |  |  |  |
| 13a. STATE   |         | 13b. CITY OR TOWN   |                   | 13d. INSIDE CITY LIMITS?   |                     | 13e. STREET ADDRESS                     |  |  |  |
| Maryland   |         | Montgomery  |                   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                     | 3453 Chiswick Court, #1-A               |  |  |  |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME  |                   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |                     | 16b. SOCIAL SECURITY NO.                |  | 17. INFORMANT ADDRESS                              |  |
| Herbert J. Mathewson   |         | Mary Jane Scrim   |                   | No   |                     | 193-26-9299                             |  | Helen M. Mathewson, wife. Address same as Item 13. |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                   |  |                     |   |  |  |  |
| PART I DEATH WAS CAUSED BY:  |         |   |                   |  |                     |   |  |  |  |
| IMMEDIATE CAUSE (a) <u>Acute myocardial disease</u>  |         |   |                   |  |                     |   |  |  |  |
| 8880   |         |   |                   |  |                     |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:  |         |   |                   |  |                     |   |  |  |  |
| (b) <u>fracture of left hip</u>  |         |   |                   | 7 weeks  |                     |   |  |  |  |
| (c) <u>fall.</u>   |         |   |                   | 7 weeks  |                     |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |         |   |                   |  |                     |   |  |  |  |
| Chronic myocardial disease and emphysema.  |         |   |                   |  |                     |   |  |  |  |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                   | 20. AUTOPSY?   |                     |   |  |  |  |
| 4/20/81  |         | Fracture of left hip.   |                   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                     |   |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.   |                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |                     |   |  |  |  |
|  |         | 4/15 19 81  |                   | Fell at home.  |                     |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC)  |                   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |                     |   |  |  |  |
|  |         | Home  |                   | Chiswick Court, Silver Spring, Montgomery, Md.   |                     |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         | TITLE (SPECIFY)   |                   | DATE SIGNED  |                     |   |  |  |  |
| ACTUAL SIGNATURE <u>John S. Rogers</u>   |         | M.D. Deputy   |                   | MEDICAL EXAMINER   |                     | 2/5/82                                  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |         | ADDRESS   |                   | 1919 Seminary Road   |                     |   |  |  |  |
| John S. Rogers, M.D.   |         | Silver Spring, Montgomery, Md.  |                   |  |                     |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         | 23b. DATE   |                   | 23c. NAME OF CEMETERY OR CREMATORY   |                     | 23d. LOCATION CITY OR TOWN COUNTY STATE |  |  |  |
| Burial   |         | 6/4/81  |                   | Gate of Heaven   |                     | Silver Spring, Montgomery, Md.          |  |  |  |
| 24. FUNERAL DIRECTOR NAME  |         | 24b. ADDRESS  |                   | 25a. DATE REC'D. BY REGISTRAR  |                     | 25b. REGISTRAR'S SIGNATURE              |  |  |  |
| Francis J. Collins   |         | 20901   |                   | JUN 8 1981   |                     |   |  |  |  |
| 500 University Blvd. West, Silver Spring, Md.  |         |   |                   |  |                     |   |  |  |  |



Item 7b 8557 7/7/81 gj

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 81 16377

|  |  |  |   |   |                     |  |  |
|--|--|--|---|---|---------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>MAUL Beatrice M. Maul M.   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>6/20/81 |   | 2b. HOUR<br>7:15 am |  |  |
| 3. SEX<br>F Female   |  | 4. RACE<br>W White   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>5 12 93  |                     | 6. AGE (IN YEARS LAST BIRTHDAY)<br>88 YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>England   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>Rochdale, England  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                     | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Kensington  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Circle Manor Nrs Nursing Home   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife   |                     | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Montgomery  |   | 13c. CITY OR TOWN<br>Kensington   |                     | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>N/A   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>N/A  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>N/A   |                     | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>093-20-9597D   |  |
| 17. INFORMANT ADDRESS<br>Beatrice M. Gudrige Rockville, Md.  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Bilateral pneumonia</u><br>4860<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>ONE WEEK  |                     |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>SEVERE ANEMIA AND ORGANIC BRAIN SYNDROME   |  |  |   |   |                     |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                     |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                     |  |  |
| 22a. I certify that (1) this hospital attended the deceased from <u>SEPT 21, 1974</u> , to <u>6/20, 1981</u> , that (1) (we) lost saw the deceased alive on <u>6/15, 1981</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. |  |  |   |   |                     |  |  |
| 22b. SIGNATURE<br>Martin C. Shargel  |  | DEGREE<br>M.D.   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |                     | 22c. DATE SIGNED<br>6/20/81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MARTIN C. SHARGEL   |  | 22e. ADDRESS<br>3720 FARRAGUT AVE<br>KENSINGTON MD - 20795   |   |   |                     |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>6/22/81   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>German Reformed Cem. Tremont  |                     | 23d. LOCATION<br>Schuylkill Pa.  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>G. Douglas Stauffer  |  | ADDRESS<br>10 Box 66 Fred. Md.   |   | 25a. DATE REC'D. BY REGISTRAR<br>JUN 25 1981  |                     | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |

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MD. DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 6 3 7 8  
**CERTIFICATE OF DEATH**

|  |  |   |  |   |   |   |   |  |  |
|--|--|---|--|---|---|---|---|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Richard Nelson McAllister</b>   |  |   | 2a. DATE OF DEATH<br>Month <b>May</b> Day <b>28</b> Year <b>1981</b>                         |   |   | 2b. HOUR <b>A</b><br><b>6:39M</b>   |   |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br><b>June 29, 1901</b>  |   | 6. AGE (In years<br>lost birthday)<br><b>79</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign<br>country) <b>Mississippi</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Montgomery</b> Md.   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Takoma Park</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) <b>Washington Adventist Hosp.</b> |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.) <b>Supply Specialist</b>   |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY <b>G.S.A.</b>  |   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE <b>District of Columbia</b>   |  | 13b. COUNTY <b>Washington</b>   |  | 13c. CITY OR TOWN <b>Washington</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |   | 13e. STREET AND NUMBER<br><b>708 Nicholson St. N.W.</b>          |  |
| 14. FATHER'S NAME<br>First <b>Richard</b> Middle <b>McAllister</b> Last <b>McAllister</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>First <b>Flora</b> Middle <b>McClellan</b> Last <b>McClellan</b> |   |   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>212-14-5474</b>  |  | 17. INFORMANT<br><b>Hazel McAllister</b>  |   | Address <b>Wash., D.C.</b><br><b>708 Nicholson St. N.W.</b>   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4920</b> IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a).<br>stating the underlying cause last. (b) <b>CHRONIC OBSTRUCTIVE LUNG DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>last. (c) <b>EMPHYSEMA</b> |  |   |  |   |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>10 MIN</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |  |   |   |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                                   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/28</b> , 19 <b>81</b> , to <b>5/28</b> , 19 <b>81</b> , that (I) (we) last<br>saw the deceased alive on <b>5/27</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Joseph B. Mizgerd, M.D.</b>   |  |   |  | DEGREE <b>MD</b>  |   | ATTENDING<br>PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>5/28/81</b>                               |  |
| 22d. PHYSICIAN'S<br>NAME (Type) <b>Joseph B. Mizgerd, M.D.</b>   |  |   |  | 22e. ADDRESS<br><b>7600 Carroll Ave., Takoma Park, Md.</b>  |   |   |   |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>1 June 1981</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>City Cemetery</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Vicksburg, Mississippi</b>  |   |  |  |
| 24. FUNERAL DIRECTOR<br><b>McGuire Funeral Serv. 7400 Georgia Ave. N.W.</b>  |  |   |  | ADDRESS <b>Wash., D.C.</b>  |   | 25a. REC'D BY REGISTRAR<br><b>JUN 23 1981</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>L. J. Brady</b>                 |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01:39

May 28, 1967

Richard Nelson Hollister

to

June 22, 1967

Black

air

conspiracy

U.S.A.

Mississippi

U.S.A.

Washington Aviation Corp. Supply Specialist

Texas Park

708 Nicholson St. N.W.

Washington

District of Columbia

John Hollister

Richard Nelson Hollister

Year, 1967

202-4-5074, 708 Nicholson St. N.W.

to

Richard Nelson

7800 Georgia Ave., Texas Park, Md.

George W. Howard, Jr.

Washington, Mississippi

City Cemetery

June 1967

Part I

Washington, D.C.

7800 Georgia Ave., N.W.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 6 3 7 9

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|   |  |   |   |   |
|---|--|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Charles J. McCarthy  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>6 21 81  |   | 2b. HOUR<br>8 p.m.  |
| 3. SEX<br>Male  | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Dec. 19, 1919   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>61   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maine  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S. A.  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.  |   |
| 10. CITY OR TOWN OF DEATH<br>Silver Spring  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Holy Cross Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Consultant                  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Electronics  |
| 13a. STATE<br>Maryland  | 13b. COUNTY<br>Montgomery  | 13c. CITY OR TOWN<br>Kensington   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles -- McCarthy   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Nora -- Donahue  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>Yes WW II   |  | 16b. SOCIAL SECURITY NO.<br>007-01-9774   |   | 17. INFORMANT<br>ADDRESS<br>1300 Timberly Lane<br>Brian J. Cummings, Jr., McLean, Virginia  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br>1539<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>Colon Cancer with</u><br>(c) <u>metastases</u>  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |   |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)       |   |   |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   |   |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |   |
| 22a. certify that (I) <del>(did not)</del> <u>viewed</u> the deceased from <u>June 21</u> , 19 <u>81</u> , to <u>June 21</u> , 19 <u>81</u> that (I) <del>(was)</del> <u>lost</u> saw the deceased alive on <u>June 21</u> , 19 <u>81</u> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated <del>(above)</del> (did) <del>(did not)</del> view the body after death. |  |   |   |   |
| 22b. SIGNATURE<br><u>John J. Merendino</u>  |  | 22c. DATE SIGNED<br>6/22/81   |   | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>6/25/81  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Gate of Heaven Cem.   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Silver Spring, Maryland   |  | 24. FUNERAL DIRECTOR<br>Joseph Gawler's Sons, Inc.<br>5130 Wisconsin Ave., NW, Washington, D.C. 20016   |   |   |
| 25a. DATE REC'D. BY REGISTRAR<br>JUN 26 1981  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Patty McBrady</u>  |   |   |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                      |  |   |  |                                |   |  |  |  | REG. NO. |  |
|--|----------------------|--|---|--|--------------------------------|---|--|--|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>RONALD KIRK MCDONALD</b>  |                      |  |   |  |                                | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <b>6-12-1981</b> |  | 2b. HOUR <b>2415</b>                           |  |          |  |
| 1. SEX <b>male</b>   | 4. RACE <b>white</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>APRIL 13, 1977</b>   | 6. AGE (IN YEARS LAST BIRTHDAY) <b>4 YRS.</b> | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.   | IF UNDER 24 HRS.<br>HOURS MIN. | 2c. DATE PRONOUNCED DEAD <b>6-12-1981</b>   |  | 2d. HOUR <b>PM</b>                             |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>SOUTH CAROLINA</b>  |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.   |  |  |  |          |  |
| 10. CITY OR TOWN OF DEATH <b>Silver Springs</b>  |                      | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b> |   |  |                                | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>N/A</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY              |  |          |  |
| 13a. STATE <b>MARYLAND</b>   |                      | 13b. COUNTY <b>MONTGOMERY</b>  |   | 13c. CITY OR TOWN <b>SILVER SPRING</b>   |                                | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS <b>11413 COLUMBIA PIKE</b> |  |          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>RONALD D. MCDONALD</b>   |                      | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>SUSAN CRENSHAW</b>  |   |  |                                |   |  |  |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>   |                      | 16b. SOCIAL SECURITY NO. <b>NO</b>   |   | 17. INFORMANT <b>SUSAN MCDONALD</b>  |                                | ADDRESS <b>SAME AS 13</b>   |  | MOTHER <b>MOTHER</b>                           |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY: <b>Undetermined</b><br><b>7999</b> IMMEDIATE CAUSE (a) <b>Undetermined</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>Undetermined</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Undetermined</b>                         |                      |  |   |  |                                |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |                      |  |   |  |                                |   |  |  |  |          |  |
| 19a. DATE OF OPERATION   |                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |  |                                | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                      | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |                                |   |  |  |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                      | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                                |   |  |  |  |          |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                      |  |   |  |                                |   |  |  |  |          |  |
| ACTUAL SIGNATURE <b>Margaret A. Korell</b>   |                      | TITLE (SPECIFY) <b>Assistant</b>   |   | M.D. <b>Assistant</b>  |                                | MEDICAL EXAMINER  |  | DATE SIGNED <b>6-13-81</b>                     |  |          |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Margaret A. Korell, M.D.</b>  |                      | ADDRESS <b>111 Penn Street</b>   |   |  |                                |   |  |  |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |                      | 23b. DATE <b>6/17/81</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY <b>BURTONSVILLE UNION</b>   |                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>BURTONSVILLE MONT MD.</b>   |  |  |  |          |  |
| 24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b>  |                      | 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901  |   | 25a. DATE REC'D. BY REGISTRAR <b>JUN 22 1981</b>   |                                | 25b. SIGNATURE <b>[Signature]</b>   |  |  |  |          |  |



RECEIVED

RECEIVED

## Medical Examiner Notified &amp; Released

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 6 3 8 1

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |   |   |   |  |   |
|--|---|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><u>John Elliott Mcintosh</u>  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><u>6 18 81</u>  |  | 2b. HOUR<br><u>12 57 PM</u>   |
| 3. SEX<br><u>MALE</u>  | 4. RACE<br><u>White</u>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><u>6 26 20</u>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>60</u> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><u>Ohio</u>   | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Montgomery</u> MD.                                 |  |   |
| 10. CITY OR TOWN OF DEATH<br><u>Takoma Park</u>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>WASHINGTON Adventist Hosp</u> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING LIFE)<br><u>Ret. School Teacher</u> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>Mont. Co. School System</u> |
| 13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE COUNTY CITY OR TOWN<br><u>Md. Carroll Mt. Airy</u>   |   | 13b. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | 13c. STREET ADDRESS<br><u>5404 Ridge Rd.</u>  |  |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><u>Elliott</u>  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><u>Emma Ghent</u>   |   | 16. ADDRESS<br><u>Address Same as No# 13c.</u>                                       |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br><u>W.W.II</u>  |   | 16b. SOCIAL SECURITY NO.<br><u>283-12-3954</u>  |   | 17. INFORMANT<br><u>Pearl D. McIntosh</u>  |   |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Artery Disease</u><br>Approximate interval between onset and death: <u>6-18 hours.</u> |   |   |   |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>   |   |   |   |  |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |   |   |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>18 June 1981</u> to <u>18 June 1981</u> , that (I) (we) lost<br>saw the deceased alive on <u>18 June 1981</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.                              |   |   |   |  |   |
| 22b. SIGNATURE<br><u>Michael Schwartz</u>  |   | DEGREE<br><u>MD</u>   |   | 22c. DATE SIGNED<br><u>18 June 81</u>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>MICHAEL SCHWARTZ</u>   |   | 22e. ADDRESS<br><u>5711 Sarvis Ave. #300 Riverdale, Md.</u>   |   |  |   |

MEDICAL CERTIFICATION

|   |                             |  |  |
|---|-----------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>Burial</u>                     | 23b. DATE<br><u>6/22/81</u> | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Bowling Green Pres.Ch. Cemetery</u> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Bowling Green York S.C.</u> |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>F. Gasch's Sons F.H. P.A. Hyattsville, Md.</u> |                             | 25a. DATE REC'D. BY REGISTRAR<br><u>JUN 22 1981</u>                          | 25b. REGISTRAR'S SIGNATURE<br><u>Robert H. Gentry</u>                        |



11/10/77

For

John E. McInnis

No. 10.

Curry County, Oregon  
Post Office  
Curry County, Oregon

12/10/77

12/10/77

12/10/77

12/10/77

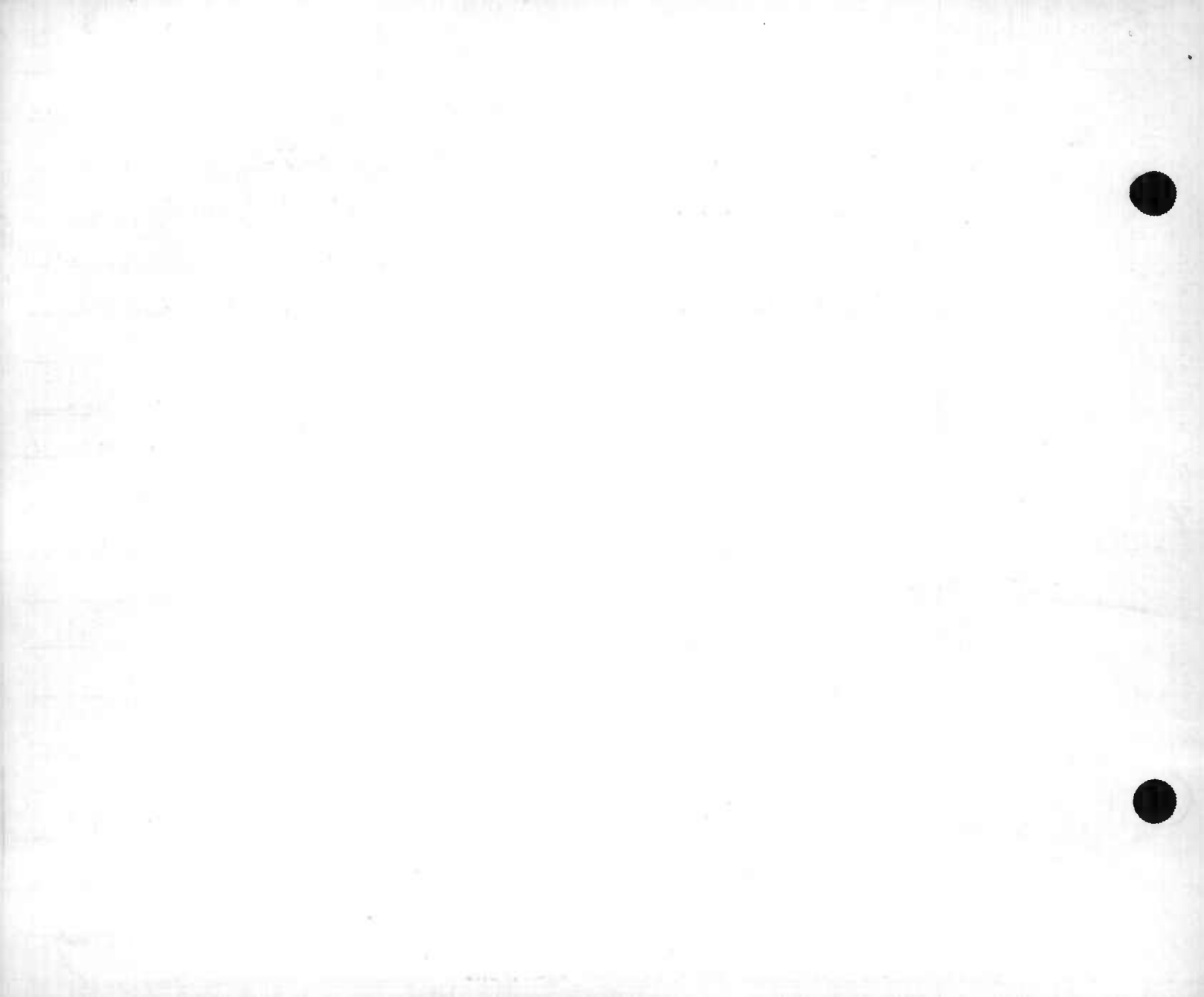
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR STATE REGISTRAR  |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 8 1 1 6 3 8 2   |  |  |  |
|--|--|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  | 2a. DATE OF DEATH  |  |   |  | 2b. HOUR  |  |  |  |
| Arthur O. Mederrick  |  |  |  | 6/11/81  |  |   |  | 5:00 P.M.   |  |  |  |
| 3 SEX  |  | 4 RACE   |  | 5 DATE OF BIRTH  |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                      |  | 7 UNDER 1 YEAR  |  | 8 UNDER 24 HRS                               |  |
| MALE   |  | White  |  | 10 11 11   |  | 69 YRS  |  | MONTHS  |  | DAYS   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b CITIZEN OF WHAT COUNTRY?  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |  |   |  |  |  |
| TEXAS  |  | U.S.A.   |  |  |  | MONTGOMERY COUNTY MD.   |  |   |  |  |  |
| 10 CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)        |  | 12b KIND OF BUSINESS OR INDUSTRY                                    |  |  |  |
| ROCKVILLE  |  | COLLINGSWOOD NURSING CENTER  |  |  |  | CAB DRIVER  |  | TRANSPORTATION  |  |  |  |
| 13a STATE  |  |  |  | 13b COUNTY   |  | 13c CITY OR TOWN  |  | 13d INSIDE CITY LIMITS?   |  |  |  |
| MARYLAND   |  |  |  | MONTGOMERY   |  | KENSINGTON  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e STREET ADDRESS                           |  |
| 14 FATHER'S NAME   |  |  |  | 15 MOTHER'S MAIDEN NAME  |  |   |  |   |  |  |  |
| ABRAHAM MEDERRICK  |  |  |  | UNKNOWN  |  |   |  |   |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  | 16b SOCIAL SECURITY NO.  |  | 17 INFORMANT (SON)  |  | ADDRESS   |  |  |  |
| NO   |  |  |  | NONE   |  | JERRY MEDERRICK   |  | 14425 BAUER DRIVE<br>ROCKVILLE, MARYLAND                            |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY  |  |  |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| IMMEDIATE CAUSE (a) Renal failure  |  |  |  |  |  |   |  |   |  | 5 days                                       |  |
| 4039 DUE TO, OR AS A CONSEQUENCE OF (b) Nephrosclerosis  |  |  |  |  |  |   |  |   |  | Years  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |  |  |  |  |   |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension  |  |  |  |  |  |   |  |   |  | Years  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |   |  |   |  |  |  |
| Normal pressure hydrocephalus  |  |  |  |  |  |   |  |   |  |  |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a AUTOPSY?  |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?       |  |  |  |
| April 1981   |  | Normal pressure hydrocephalus  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |  |  |
|  |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |   |  |   |  |  |  |
|  |  | P.M. 19  |  |  |  |   |  |   |  |  |  |
| 21d INJURY OCCURRED  |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                     |  | 21f LOCATION   |  | CITY OR TOWN  |  | COUNTY  |  | STATE  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  |  |  |   |  |   |  |  |  |
| 22 I certify that (I) (the hospital) attended the deceased from Feb 19 81 to 6/11 19 81, that (I) (we) last saw the deceased alive on 5/12 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |   |  |  |  |
| 22b SIGNATURE  |  |  |  | DEGREE   |  |   |  | 22c DATE SIGNED   |  |  |  |
| Sidney J. Cohen M.D.   |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                 |  |   |  | 6/11/81   |  |  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e ADDRESS  |  |   |  |   |  |  |  |
| Sidney J. Cohen, MD  |  |  |  | 121 Congressional Ave, Rockville, Md   |  |   |  |   |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b DATE   |  | 23c NAME OF CEMETERY OR CREMATORY  |  | 23d LOCATION  |  | COUNTY  |  | STATE  |  |
| BURIAL   |  | June 3, 1981   |  | OHEV SHOLOM CEMETERY   |  | WASHINGTON  |  | COUNTY  |  | DC   |  |
| 24 FUNERAL DIRECTOR  |  |  |  | 25a DATE RECEIVED BY REGISTRAR   |  |   |  | 25b REGISTRAR'S SIGNATURE   |  |  |  |
| NAME DANZANSKY-GOLDBERG CHAPELS  |  |  |  | ADDRESS 1170 ROCKVILLE PIKE  |  |   |  | JUN 5 1981  |  |  |  |





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

16383

|   |                             |  |   |   |   |  |   |  |
|---|-----------------------------|--|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>DANIEL H. MELTON</b>   |                             |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <b>6-14 1981</b>                   |   |   | 2b. HOUR <b>A</b>  |   |  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>Caucasian</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>March 31 1951</b>   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>30 YRS.</b>                    | IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN.  |   | 2c. DATE PRONOUNCED DEAD<br><b>June 14 1981</b>                          |   | 2d. HOUR<br><b>7 P</b>                           |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Washington, D.C.</b>  |                             | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.            |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Gaithersburg</b>  |                             | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>17620 Sequoia Dr.</b> |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Automotive mechanic</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>auto</b>                                    |  |
| 13a. STATE<br><b>Maryland</b>   |                             |  | 13b. CITY OR TOWN<br><b>Montgomery</b>                                  |   |   | 13c. STREET ADDRESS<br><b>Gaithersburg 17620 Sequoia Dr.</b>             |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William H. Melton</b>  |                             |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Coryne Shockley</b> |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>yes</b>   |                             | 16b. SOCIAL SECURITY NO.<br><b>218-56-9120</b>   |   | 17. INFORMANT ADDRESS<br><b>Wm. H. Melton 13907 Vista Dr., Rockville, Md</b>  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Gun Shot Wound of Head;</b><br><b>9550</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>Self-Inflicted.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF |                             |  |   |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH     |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |                             |  |   |   |   |  |   |  |
| 19a. DATE OF OPERATION  |                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |   |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>7 am 6-14 1981</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Shot self with 22 cal. Hand. gun -</b>                                  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                             | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>apt.</b>   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>17620 Sequoia Dr. Gaithersburg Mont. Md.</b>  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>   |                             |  |   | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion               |   |  |   |  |
| ACTUAL SIGNATURE<br><b>John G. Ball</b>   |                             | TITLE (SPECIFY)<br><b>Deputy</b>   |   | MEDICAL EXAMINER  |   | DATE SIGNED <b>June 14 1981</b>  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>John G. Ball, M.D.</b>  |                             | ADDRESS<br><b>7936 Old Georgetown Rd., Bethesda, Maryland</b>  |   |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>   |                             | 23b. DATE<br><b>June 15, 1981</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Metropolitan Crematory</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Alexandria Virginia</b> |   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Robert A. Pumphrey</b>  |                             |  |   | FUNERAL HOMES P/A<br><b>300 W. Montgomery Ave., Rockville, Md. 20850</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 18 1981</b>                      |   | 25b. REGISTRAR'S SIGNATURE<br><b>L. H. H. H.</b> |

MEDICAL CERTIFICATION

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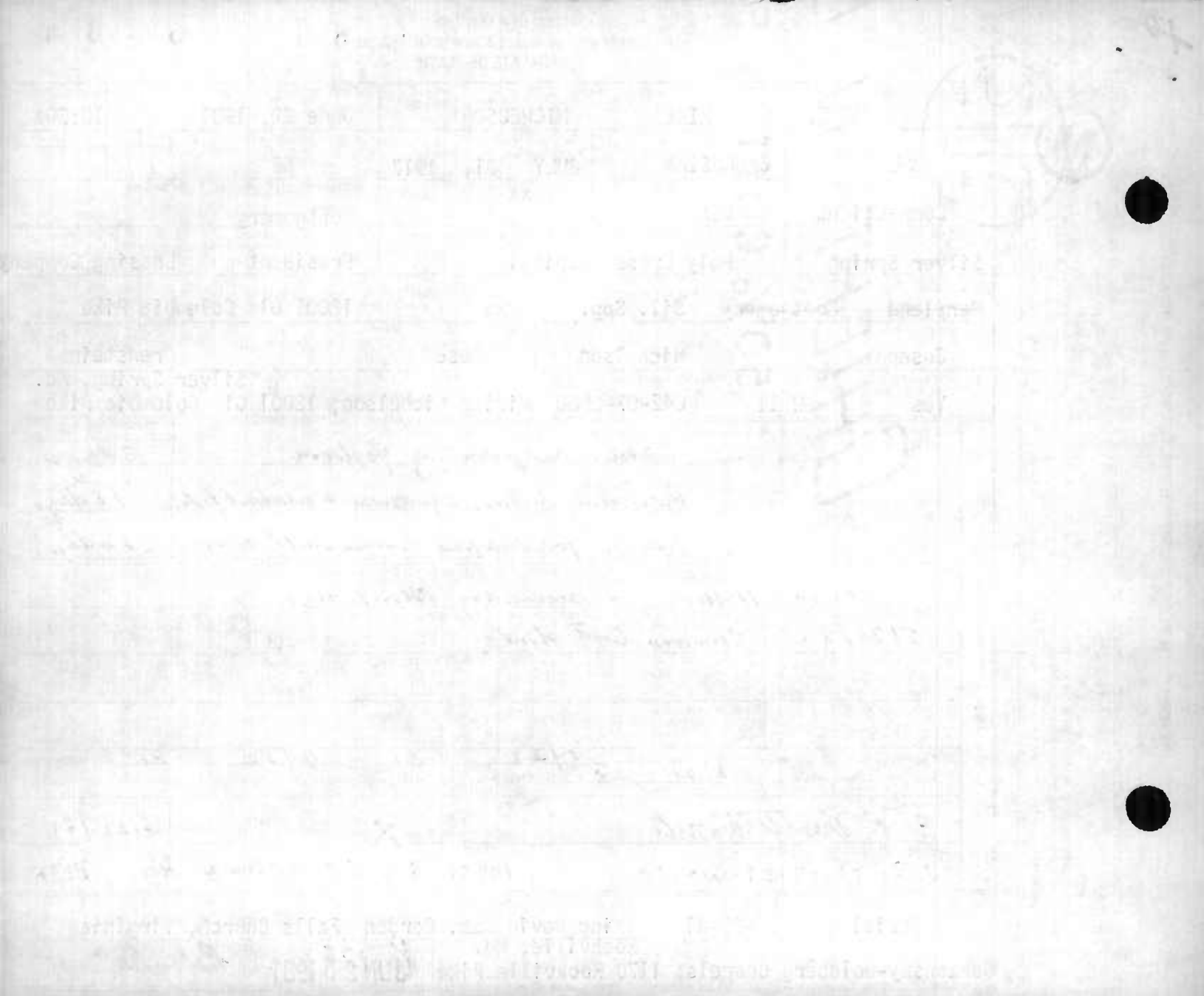
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |   |   |   |                     |  |  |
|--|--|--|--|---|---|---|---------------------|--|--|
| CERTIFICATE OF DEATH   |  |  |  |   |   |   |                     |  |  |
| REG. NO. 8 1 1 6 3 8 4   |  |  |  |   |   |   |                     |  |  |
| 1- FOR STATE REGISTRAR   |  |  |  |   |   |   |                     |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>S. MIKE MICHELSON   |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>June 22, 1981 |   | 2b. HOUR<br>10:30aM |  |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>CAUCASIAN   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>JULY 31, 1917   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>63 YRS.  |                     | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Connecticut  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.  |                     |  |  |
| 10. CITY OR TOWN OF DEATH<br>Silver Spring   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Holy Cross Hospital |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>President                   |                     | 12b. KIND OF BUSINESS OR INDUSTRY<br>Leasing Company   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   |   |   |                     |  |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Montgomery  |  | 13c. CITY OR TOWN<br>Sil. Spg.  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                     | 13e. STREET ADDRESS<br>12001 Old Columbia Pike   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Joseph Michelson   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Rose Orenstein   |   |   |                     |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WW 11   |  | 17. INFORMANT<br>ADDRESS: Silver Spring, Md.<br>Miriam Michelson; 12001 Old Columbia Pike   |   |   |                     |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |   |   |   |                     |  |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio respiratory failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Repetent distress syndrome + intestinal perforation</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Operation for recurrent common duct stone</u>  |  |  |  |   |   |   |                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>3 days</u><br><u>18 days</u><br><u>22 days</u>                          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Renal failure + secondary hemorrhage</u>   |  |  |  |   |   |   |                     |  |  |
| 19a. DATE OF OPERATION<br><u>5/30/81</u>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>Common duct stone</u>   |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |   |                     |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |                     |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/28</u> , 19 <u>81</u> , to <u>6/22</u> , 19 <u>81</u> , that (I) (we) lost<br>saw the deceased alive on <u>6/21</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |   |                     |  |  |
| 22b. SIGNATURE<br><u>J. R. Thistlethwaite</u>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |   |   |                     | 22c. DATE SIGNED<br><u>6/22/81</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>J. R. Thistlethwaite</u>   |  |  |  | 22e. ADDRESS<br><u>10401 Old Georgetown Rd, Bethesda</u>  |   |   |                     |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>6-23-81   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>King David Mem. Garden  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Falls Church, Virginia                            |                     |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Danzansky-Goldberg Chapels; 1170 Rockville Pike  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 25 1981  |   | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |                     |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If a delay may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-6868.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |   |  |   |  |  |   |  |   |  |
|---|--|---|--|---|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Sarah Miller</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>June 23, 1981</b>                   |   |  | 2b. HOUR<br><b>7:41AM</b>  |   |  |   |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>CAUCASIAN</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>JULY 15, 1896</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b> YRS   |   | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS. HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>RUSSIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Olney</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Montgomery General Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>-----   |   |  |
| 13a. STATE<br><b>DIST. of COL</b>   |  |   | 13b. CITY OR TOWN<br><b>WASHINGTON</b>                                     |   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |  | 13d. STREET ADDRESS<br><b>821 Crittenden Street, N.E.</b> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>YUDA MORDECAI DORRIS</b>  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>CHIA LIBBE GOLDENBERG</b> |   |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>NONE</b>     |   |  | 17. INFORMANT (Son-in-Law) ADDRESS<br><b>MAURICE MYERS 3905 Palmira Lane Silver Spring, Maryland</b>   |   |  |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Renal failure.</b><br><b>2765</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Dehydration.</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Aphagia of unknown cause</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 days.</b><br><b>1 week.</b><br><b>4 weeks.</b> |  |   |  |   |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>① Congestive cardiomyopathy. ② Thirst.</b>  |  |   |  |   |  |  |   |  |   |  |
| 19a. DATE OF OPERATION<br>-----   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>-----                  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                    |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)        |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>May</b> , 19 <b>81</b> , to <b>6/23</b> , 19 <b>81</b> ; that (I) (we) last saw the deceased alive on <b>6/22</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>J. Maltz</b>   |  |   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>6/23/81</b>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JONATHAN MALTZ.</b>   |  |   |  |   |  | 22e. ADDRESS<br><b>1811 Prince Philip Drive, Olney, Md. 20832.</b>   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  |   | 23b. DATE<br><b>June 24, 81</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ADAS ISRAEL CONGREGA.</b> |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>WASHINGTON DC</b> |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Shanky-Loubers</b>  |  |   |  |   |  | ADDRESS<br><b>Rockville, Md.</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 25 1981</b>  |   |  |
|   |  |   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |   |  |   |  |

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMH - 16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |  |   |  |  |                               | 8 1 1 6 3 8 6  |  |
|---|--|---|--|---|--|---|--|--|-------------------------------|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   |  |   |  |  |                               | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARY ANN MINTON</b>  |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>June 27, 1981</b>  |  |  | 2b. HOUR<br><b>11:40 A.M.</b> |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br><b>July 11, 1911</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |                               | IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Illinois</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery MD</b>  |  |  |                               |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Suburban Hospital</b> |  |   |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |                               | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>   |  |
| 13a. STATE<br><b>Florida</b>  |  | 13b. COUNTY<br><b>Broward</b>   |  | 13c. CITY OR TOWN<br><b>Ft. Lauderdale</b>  |  | 13d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 13e. STREET ADDRESS<br><b>511 Bayshore Drive #707</b>                                |                               |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William C. Camden</b>  |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Minnie C. Jackson</b>   |  |  |                               |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>220-56-7154</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Robert E. Minton, Same as #13</b>  |  |  |                               |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of Colon</b><br><b>1539</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF |  |   |  |   |  |   |  |  |                               | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 years</b>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |   |  |   |  |   |  |  |                               |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                               | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |                               |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |                               |  |  |
| 22a. I certify that (this hospital) attended the deceased from <b>6-11</b> , 19 <b>81</b> , to <b>6-27</b> , 19 <b>81</b> , that (we) last saw the deceased alive on <b>6-27</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) view the body after death.                               |  |   |  |   |  |   |  |  |                               |  |  |
| 22b. SIGNATURE<br><b>John Tauber</b>  |  |   |  |   |  | DEGREE<br><b>M.D.</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |                               | 22c. DATE SIGNED<br><b>6-27-81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>John Tauber</b>   |  |   |  |   |  | 22e. ADDRESS<br><b>8218 Wisconsin Ave Md.</b>   |  |  |                               |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>   |  |   |  | 23b. DATE<br><b>June 28, 1981</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Metropolitan Crem.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Alexandria, Virginia</b>            |                               |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland</b>  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 1 - 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Patricia McBrady</b>                                |                               |  |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

(M)

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |   |   |  |   |  |
|---|--|---|--|--|---|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  |  | 8 1 1 6 3 8 7   |   |  |   |  |
| I. DECEASED NAME<br>(TYPE OR PRINT) <b>NELSON PAUL MITCHELL</b>   |  |   |  |  | 2a. DATE OF DEATH<br>MONTH <b>JUNE</b> DAY <b>24</b> YEAR <b>1981</b> |   |  |   |  |
| 3 SEX<br><b>Male</b>  |  | 4 RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>Feb.</b> DAY <b>24</b> YEAR <b>1904</b>   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS   |  | 7b HOUR<br><b>2:45</b> P.M.   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maine</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>US</b>  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 <b>BALTIMORE CITY OR COUNTY OF DEATH</b><br><b>Montgomery</b> MD.   |  |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Kensington</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Kensington Gardens N.H.</b> |  |  |   | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Printer</b>   |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Printing, Co.</b>  |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE <b>Md.</b> 13b COUNTY <b>Montgomery</b>  |  | 13c CITY OR TOWN<br><b>Bethesda</b>   |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 13e STREET ADDRESS<br><b>5471 Wilson La.</b>  |  |   |  |
| 14 FATHER'S NAME<br>FIRST <b>Walter</b> MIDDLE <b>--</b> LAST <b>Mitchell</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Charlotte</b> MIDDLE <b>--</b> LAST <b>Mitchell</b>   |   |   |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  |   |  | 16b SOCIAL SECURITY NO.<br><b>578-01-9860</b>  |   | 17 INFORMANT<br>ADDRESS<br><b>Isabel Mitchell Same as item # 13</b>   |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma</b><br><b>1991</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>COPD</b><br>(c) <b>DUE TO, OR AS A CONSEQUENCE OF</b>      |  |   |  |  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |   |  |  |   |   |  |   |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |   | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)  |   |   |  |   |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>June 17</b> 19 <b>81</b> to <b>June 24</b> 19 <b>81</b> that (I) (we) last saw the deceased alive on <b>19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death |  |   |  |  |   |   |  |   |  |
| 22b. SIGNATURE<br><i>G. Bowditch Hunter, Jr.</i>  |  |   |  |  |   | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>6/25/81</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>G. Bowditch Hunter, Jr. M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>50 W. Edmonston Dr. Rockville Md.</b>   |   |   |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>  |  | 23b DATE<br><b>6/26/81</b>  |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Crematory</b>   |   | 23d LOCATION<br>CITY OR TOWN <b>Suitland, Md.</b> COUNTY STATE  |  |   |  |
| 24 FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b><br>NAME <b>5130 Wisc. Ave. N.W. Wash., D.C.</b> ADDRESS   |  |   |  |  |   | 25a. DATE REC'D. BY REGISTRAR <b>JUN 29 1981</b> 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |  |



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Items #18a-22a Film G557 7/16/81 r STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

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|   |         |  |  |  |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |
|---|---------|--|--|--|--|---|--|--------------------------------------|--|--------------------------------|--|-------|--|------|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |         | FIRST  |  | MIDDLE   |  | LAST  |  | 2a. DATE KNOWN<br>OF DEATH           |  | MONTH                          |  | DAY   |  | YEAR |  | 2b. HOUR |  |
| LOTTIE  |         | Estelle  |  | MOORE  |  |   |  | 6-1-                                 |  | 81                             |  | 19    |  |      |  | 1:30 PM  |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)   |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS.                     |  | 7c. DATE<br>PRONOUNCED<br>DEAD |  | MONTH |  | DAY  |  | YEAR     |  |
| female  | white   | Oct. 29, 1900  |  | 80 YRS.  |  |   |  |                                      |  | 6-1-                           |  | 81    |  | 19   |  | P.M.     |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                           |  | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |                                |  |       |  |      |  |          |  |
| Virginia  |         | USA  |  |  |  |   |  | Montgomery County                    |  |                                |  |       |  |      |  |          |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION   |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)                                     |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY  |  |                                      |  |                                |  |       |  |      |  |          |  |
| Silver Spring   |         | Holy Cross Hospital  |  | Housewife  |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |
| 13a. STATE  |         | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS                  |  |                                |  |       |  |      |  |          |  |
| Md.   |         | Mont.  |  | S.S.   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |  | 3321 S. Leisure World Blvd.          |  |                                |  |       |  |      |  |          |  |
| 14. FATHER'S NAME   |         | 15. MOTHER'S MAIDEN NAME   |  |  |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |
| James   |         | Richard  |  | Sullivan   |  | Dallie  |  | E.                                   |  | Paytes                         |  |       |  |      |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  |         | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |
| None  |         | 577 05 9841  |  | 12632 Farnell Drive Wheaton, Md.   |  | Charlotte S. Maple (Daughter)   |  |                                      |  |                                |  |       |  |      |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1 DEATH WAS CAUSED BY:   |         | Arteriosclerotic cardiovascular disease and  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |
| IMMEDIATE CAUSE (a):  |         | 8880   |  |  |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause lost.  |         | DO NOT OK AS A CONSEQUENCE OF  |  | focal bronchopneumonia   |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |
| (b):  |         | DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |
| (c):  |         |  |  |  |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1  |         | Contusion of brain   |  |  |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY?   |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |
|   |         |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                  |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>? P.M. 5/1/ 19 81   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                        |  | subject fell  |  |                                      |  |                                |  |       |  |      |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>  |         | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)<br>Nursing Home   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>11901 Georgia Ave. Silver Spring Montg. Co. Md. |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |
| 22a. I certify that I took charge of the remains described above, held an   |         | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |  |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |
| death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |  |  |  |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |
| ACTUAL<br>SIGNATURE   |         | TITLE (SPECIFY)  |  | DATE<br>SIGNED   |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |
| Margarita A. Korell, M.D.   |         | M.D. Assistant   |  | 6-2-81   |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)  |         | ADDRESS  |  |  |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |
| Margarita A. Korell, M.D.   |         | 111 Penn Street  |  |  |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>SPECIFY  |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN   |  | COUNTY                               |  | STATE                          |  |       |  |      |  |          |  |
| Burial  |         | 6/4/81   |  | Arlington Cemetery   |  | Arlington, Va.  |  |                                      |  |                                |  |       |  |      |  |          |  |
| 24. FUNERAL DIRECTOR  |         | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |
| Hines/Rinaldi F.H. 11800 N.H. Ave. S.S. Md.   |         | JUN 5 1981   |  | [Signature]  |  |   |  |                                      |  |                                |  |       |  |      |  |          |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 8116389   |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | 20. DATE OF DEATH MONTH DAY YEAR 2b HOUR   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM S. MOREFIELD  |  |  |  | JUNE 19, 1981 6:20 p.m.  |  |  |  |
| 3. SEX MALE  |  | 4. RACE NEGRO  |  | 5. DATE OF BIRTH MONTH DAY YEAR NOV 3, 1925  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia   |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.   |  |
| 10. CITY OR TOWN OF DEATH BETHESDA   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE CLINICAL CENTER |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cook Self-Employed   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE D.C. 13b. CITY OR TOWN Wash. D.C. 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  | 13d. STREET ADDRESS 3141 24th St. N.E.   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Morefield  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Homie Spraggin  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes  |  | 16b. SOCIAL SECURITY NO. WWII 227-22-5835  |  | 17. INFORMANT ADDRESS Frances Ray (Sister) 3141 24th St. N.E.  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 2000 Cardiorespiratory failure<br>DUE TO, OR AS A CONSEQUENCE OF Chronic obstructive pulmonary disease with extensive bilateral pleural adhesions.<br>DUE TO, OR AS A CONSEQUENCE OF Abdominal histiocytic lymphoma in relapse Arteriosclerosis<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from APRIL 9, 1981, to JUNE 19, 1981, that (we) lost saw the deceased alive on JUNE 19, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.   |  |  |  |  |  |  |  |
| 22b. SIGNATURE DOUGLAS B. CLAYNEY, MD  |  |  |  | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED 21 JUN 81   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DOUGLAS B. CLAYNEY, MD   |  |  |  | 22e. ADDRESS NATIONAL INSTITUTES OF HEALTH CLINICAL CENTER, BETHESDA, MARYLAND 20205   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial   |  | 23b. DATE 6/26/81  |  | 23c. NAME OF CEMETERY OR CREMATORY Washington Nat. Cemetery Suitland PG Maryland   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |
| 24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home 11800 N.H. Ave. S.S. Md.  |  |  |  | 25a. DATE REC'D BY REGISTRAR JUN 25 1981   |  | 25b. REGISTRAR'S SIGNATURE   |  |



RECEIVED  
JAN 10 1964  
U.S. AIR FORCE  
HONOLULU, HAWAII

*[Faint, illegible text and markings are visible across the page, possibly bleed-through from the reverse side.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 1 1 6 3 9 0  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | CERTIFICATE OF DEATH   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  | 2a. DATE OF DEATH  |  |  |  |
| John BARKER MORRIS  |  |  |  | 6 8 81 9:30 P.M.   |  |  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |  |
| Male  |  | White  |  | March 27, 1890   |  | 91 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |
| Maryland  |  | U.S.A.   |  |  |  | Montgomery Co. MD.   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NONE SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| Wheaton   |  | University Nursing Home  |  | Service Director   |  | Dept. Store  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13b. CITY OR TOWN  |  | 13c. INSIDE CITY LIMITS?   |  | 13d. STREET ADDRESS  |  |
| Maryland  |  | Montgomery Rockville   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 10500 Rockville Pike   |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  | 16. SOCIAL SECURITY NO   |  | 17. INFORMANT  |  |
| Francis Morris  |  | Elizabeth Adams  |  | 577-07-3803  |  | Ruth E. Morris, Same address as #13.                           |  |
| 18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 18b. SOCIAL SECURITY NO  |  | 17. INFORMANT  |  | ADDRESS  |  |
| No  |  | 577-07-3803  |  | Ruth E. Morris, Same address as #13.   |  |  |  |
| 18. CAUSE OF DEATH: (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |  |  |
| PART 1: DEATH WAS CAUSED BY:  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a): arteriosclerotic heart disease 5 yrs   |  |  |  |  |  |  |  |
| 4140 DUE TO, OR AS A CONSEQUENCE OF (b): generalized arteriosclerosis   |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (c):  |  |  |  |  |  |  |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
|   |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |  |  |
|   |  | P.M. 19  |  |  |  |  |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                  |  | 21f. LOCATION  |  |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  | STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from 19 65 to 6-8 81, that I saw the deceased alive on 6-8 81, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. |  |  |  |  |  |  |  |
| 22a. SIGNATURE  |  |  |  | DEGREE   |  | 22c. DATE SIGNED   |  |
| George F. Sengstack   |  |  |  |  |  | 6-8-81   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS   |  |  |  |
| George F. Sengstack   |  |  |  | 9241 Columbia Blvd S.S. md 20910   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION  |  |
| Burial  |  | 6/11/81  |  | Ft. Lincoln Cemetery   |  | Brentwood, Maryland  |  |
| 24. FUNERAL DIRECTOR  |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE                                     |  |
| Joseph Gawler's Sons, Inc.  |  |  |  | JUN 12 1981  |  | Ruth E. Morris   |  |
| 5130 Wisconsin Ave., NW, Washington, D.C. 20016   |  |  |  |  |  |  |  |

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DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

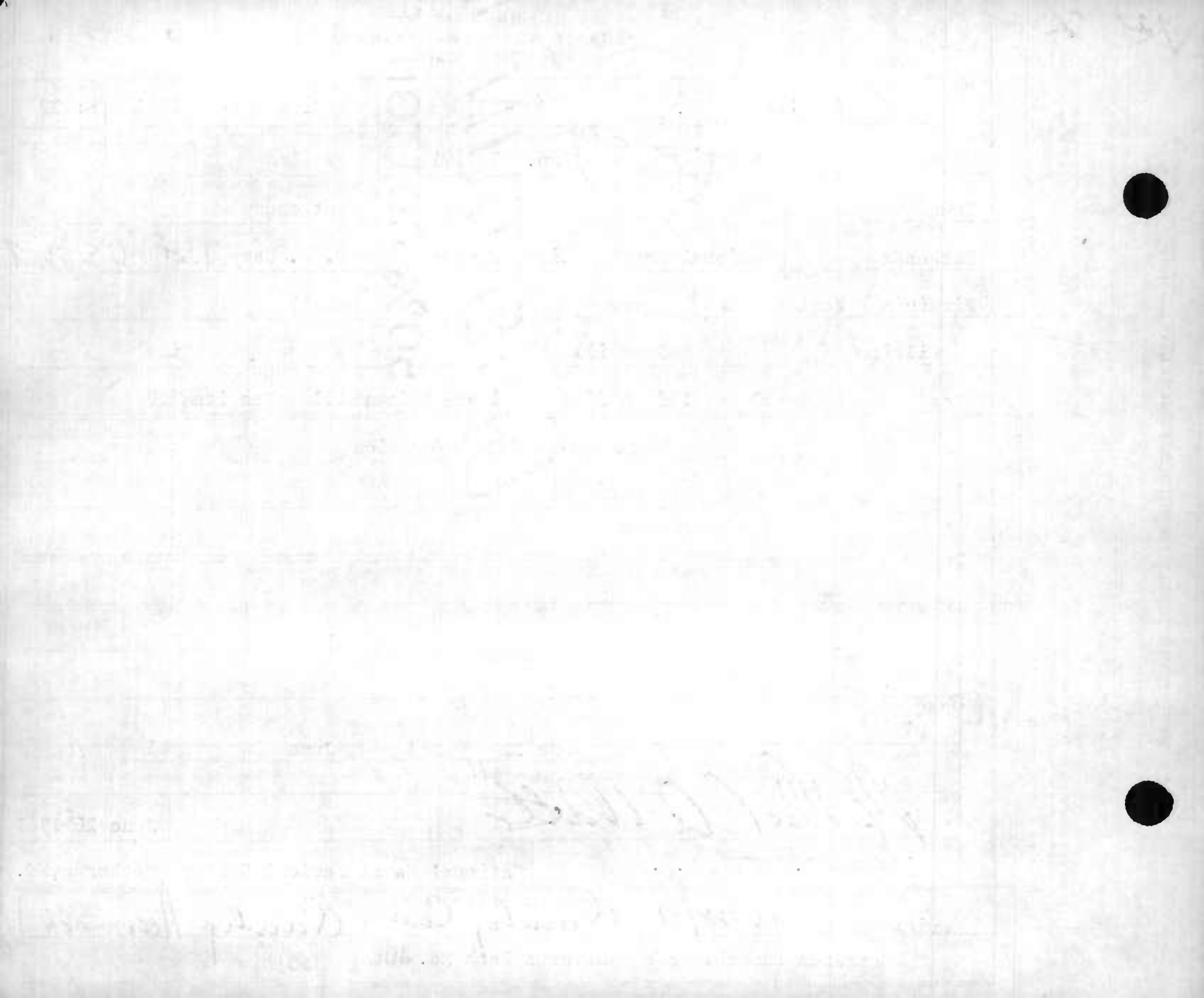
REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |   |   |  |  |  |
|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>William B. MULVERHILL</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>June 24 1981</b>                                     |  | 2b. HOUR<br><b>8:03P</b>                           |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>Caucasian</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan. 7 1919</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b><br>YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Iowa</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>National Naval Medical Center</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>U. S. Navy</b>          |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>US Int</b> |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br><b>Virginia Northampton Exmore</b> |   |   | 13d. INSIDE CITY LIMITS<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b>Box 17</b>                             |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Mulverhill</b>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Irene King</b>                             |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>1936-57</b>   | 17. INFORMANT ADDRESS<br><b>Elmyra Mulverhill See item 13</b>                                  |  |  |

|  |  |  |  |  |   |
|--|--|--|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4100</b> IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b>  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                      |   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  | (b) _____  |   |
|  |  |  |  | (c) _____  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) _____   |  |  |  |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)      |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that I (this hospital) attended the deceased from <b>June 22 1981</b> to <b>June 24 1981</b> that I (we) last saw the deceased alive on <b>June 24 1981</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If not, and I did not view the body after death, so state.) |  |  |  |  |   |
| 22b. SIGNATURE<br><b>Michael A. Watts</b>  |  |  |  | 22c. DATE SIGNED<br><b>June 26 1981</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Michael A. WATTS, M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>National Naval Medical Center, Bethesda, Md.</b>                  |   |

|  |                             |   |   |
|--|-----------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>6/28/81</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Quincy Cem</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Quincy Accomack Va</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Barranca Funeral Home</b> |                             | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 1 1981</b>      |   |
| ADDRESS<br><b>Severna Park Md.</b>                           |                             | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>        |   |



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1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |   |   |  |   |  |  |  |  |  |
|--|--|---|---|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Catherine — MUNSON</b>  |  |   | 2a. DATE OF DEATH<br>MONTH <b>6</b> DAY <b>14</b> YEAR <b>81</b>  |   |  | 2b. HOUR <b>2:48 PM</b>   |  |  |  |  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>   |   | 5. DATE OF BIRTH<br>MONTH <b>10</b> DAY <b>18</b> YEAR <b>1992</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>88</b> YRS.                                     |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>AUSTRALIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.                         |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TAKOMA PARK</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>WASHINGTON ADVENTIST HOSPITAL</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOME MAKER</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY                                      |  |  |  |
| 13a. STATE<br><b>MARYLAND</b>  |  |   | 13b. COUNTY<br><b>MONT.</b>   |   | 13c. CITY OR TOWN<br><b>SILVER SPRING</b>                                |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>2844 SHANNONDALE DRIVE</b>   |  |  |
| 14. FATHER'S NAME<br>FIRST <b>GEORGES</b> MIDDLE <b>ANNES</b> LAST <b>WINKS</b>  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>SARAH JANE</b> MIDDLE <b>CALDWELL</b> LAST <b>CALDWELL</b>   |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  |   | 16b. SOCIAL SECURITY NO.<br><b>566-50-9584B</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>DAVID H. BAASCH - 2844 SHANNONDALE DR</b> |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Embolus to the Brain Stem</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Atrial Fibrillation</b><br>3 years plus<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Atherosclerotic Heart Disease</b><br>3 yrs. plus |  |   |   |   |  |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>18 hours</b>   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:10<br><b>Atherosclerosis Obliterans - right lower extremity, femoral artery, atherosclerosis</b>   |  |   |   |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>6/13/81</b>   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Atherosclerosis Obliterans - right lower extremity, femoral artery</b> |   |  |   | 19c. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOT FOR MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |   |  | 21c. HOW INJURY OCCURRED: (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)      |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                     |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>May 1978</b> to <b>6/14/81</b> , that (I) (we) last saw the deceased alive on <b>6/14/81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Alan R. Gair MD</b>   |  |   |   | DEGREE  |  |   |  | 22c. DATE SIGNED<br><b>6/14/81</b>                                     |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Alan R. Gair MD</b>  |  |   |   | 22e. ADDRESS<br><b>11700 Old Columbia Pike Silver Spring, Md</b>  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>June 17, 1981</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Fort Lincoln Cemetery</b>       |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore P.Y. Md</b> |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Takoma Funeral Home</b>   |  |   |   | ADDRESS<br><b>9400 254 Carroll Ave. NW DC</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 17 1981</b>                    |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. [Signature]</b> |  |



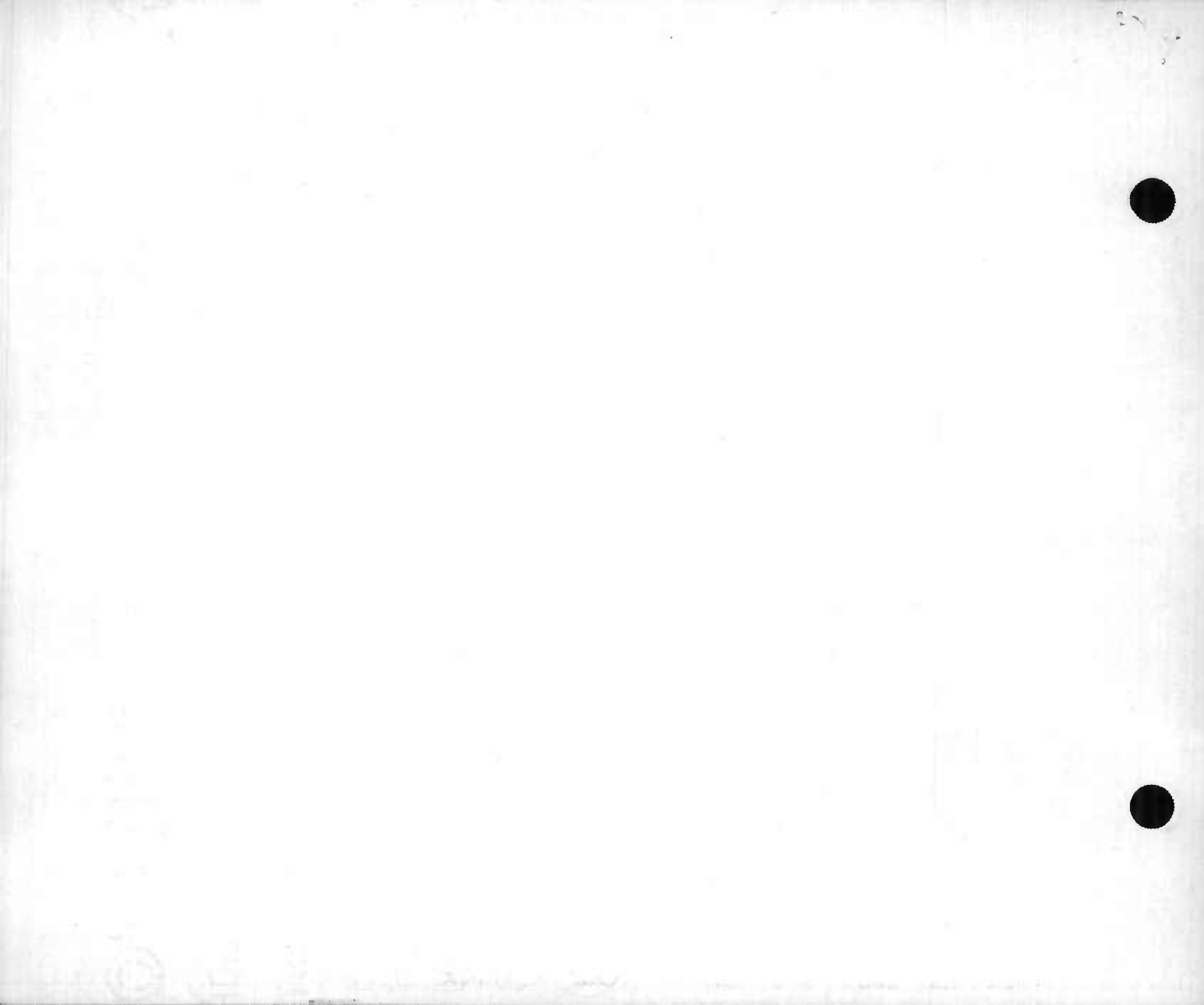


TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |   |  |  |  |   |  | 8  | 1   | 1   | 6 | 3 | 9 | 3 |
|--|--|---|--|---|--|--|--|---|--|--|---|---|---|---|---|---|
| 1. FOR<br>STATE<br>REGISTRAR   |  |   |  |   |  |  |  |   |  | REG. NO.   |   |   |   |   |   |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>HELEN ROSE MYERS</b>   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6 29 81</b>  |  |  |   |  | 2b. HOUR<br><b>700 P</b>                             |   |   |   |   |   |   |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>white</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 4 1890</b>  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>90</b> YRS.  |   |  | # UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b>          |   | # UNDER 24 HRS<br>HOURS MIN<br><b>0 0</b> |   |   |   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Washington, DC</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                              |   |  |  |   |   |   |   |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>10012 Grayson Avenue,</b> |  |   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>       |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>own home</b> |   |   |   |   |   |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |  |   |  |   | 13b. COUNTY<br><b>Montgomery</b>   |  | 13c. CITY OR TOWN<br><b>Sil. Spring</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET ADDRESS<br><b>10012 Grayson Avenue,</b> |   |   |   |   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William T. Essex</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rose I. Kline</b>  |  |  |   |  |  |   |   |   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  |   |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>215-48-8610</b>  |  | 17. INFORMANT (son) <b>2120 Ellis Street,</b><br><b>Ernest J. Myers-Silver Spring, Md.</b> |   |  |  |   |   |   |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA OF LUNG</b><br><b>1539</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>CARCINOMA OF COLON</b><br>(c) <b>DUE TO, OR AS A CONSEQUENCE OF</b>      |  |   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH         |   |   |   |   |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |  |   |  |  |   |   |   |   |   |   |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |   |   |   |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |  |   |   |   |   |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |  |   |   |   |   |   |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>Dec</b> , 19 <b>79</b> , to <b>JUNE 29</b> , 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>JUNE 29</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |   |  |  |   |   |   |   |   |   |
| 22b. SIGNATURE<br><b>Bernard A. Fitzgerald M.D.</b>  |  |   |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |   |  | 22c. DATE SIGNED<br><b>6-24-81</b>                   |   |   |   |   |   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BERNARD A. FITZGERALD</b>  |  |   |  |   | 22e. ADDRESS<br><b>217 UNIVERSITY BLVD E, SILVER SPRING MD,</b>  |  |  |   |  |  |   |   |   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>7-2-1981</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet Cemetery</b>   |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Washington, DC</b> |  |  |   |   |   |   |   |   |
| 24. FUNERAL DIRECTOR<br><b>Warner E. Pumphrey, Inc.</b>  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 1 - 1981</b>   |  |  |   |  |  |   |   |   |   |   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Karl K. [Signature]</b>   |  |   |  |   |  |  |  |   |  |  |   |   |   |   |   |   |



BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |   |  |  |
|---|--|--|--|---|--|--|---|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO. 8116394   |  |   |  |  |   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Bruce Duncan Nichols  |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>June 18 1981          |  |   | 2b. HOUR<br>9:00P M  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Caucasian   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Feb. 28 1918  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>63 YRS  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>New Jersey  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.                               |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>National Naval Medical Center |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired          |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY<br>Virginia Loudoun  |  |  |  |   | 13c. CITY OR TOWN<br>Middleburg                              |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Edward Remington Nichols  |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anne Barton |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WWII  |  | 17. INFORMANT<br>ADDRESS<br>TN<br>Brooke Bradley 1408 Woodmont Blvd. Nashville  |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u><br>1629<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <u>adenocarcinoma of lung with metastasis to skin</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) <u>skin</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.  |  |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |  |
| 22a. I certify that I (this hospital) attended the deceased from June 17 19 81 to June 18 19 81, that (I) (we) lost<br>saw the deceased alive on June 18 19 81, and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above. I (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br>Mark O. Browning M.D.   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |  |   | 22c. DATE SIGNED<br>June 19, 1981  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Mark O. Browning, M.D.   |  |  |  | 22e. ADDRESS<br>National Naval Medical Center, Bethesda, Md.  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation   |  | 23b. DATE<br>6-19-81   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Metropolitan Crematory  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Alexandria, Virginia                   |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Royston Funeral Home Middleburg, Va.  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 25 1981  |  | 25b. REGISTRAR'S SIGNATURE<br>L. J. Bradley  |   |  |  |

MEDICAL CERTIFICATION



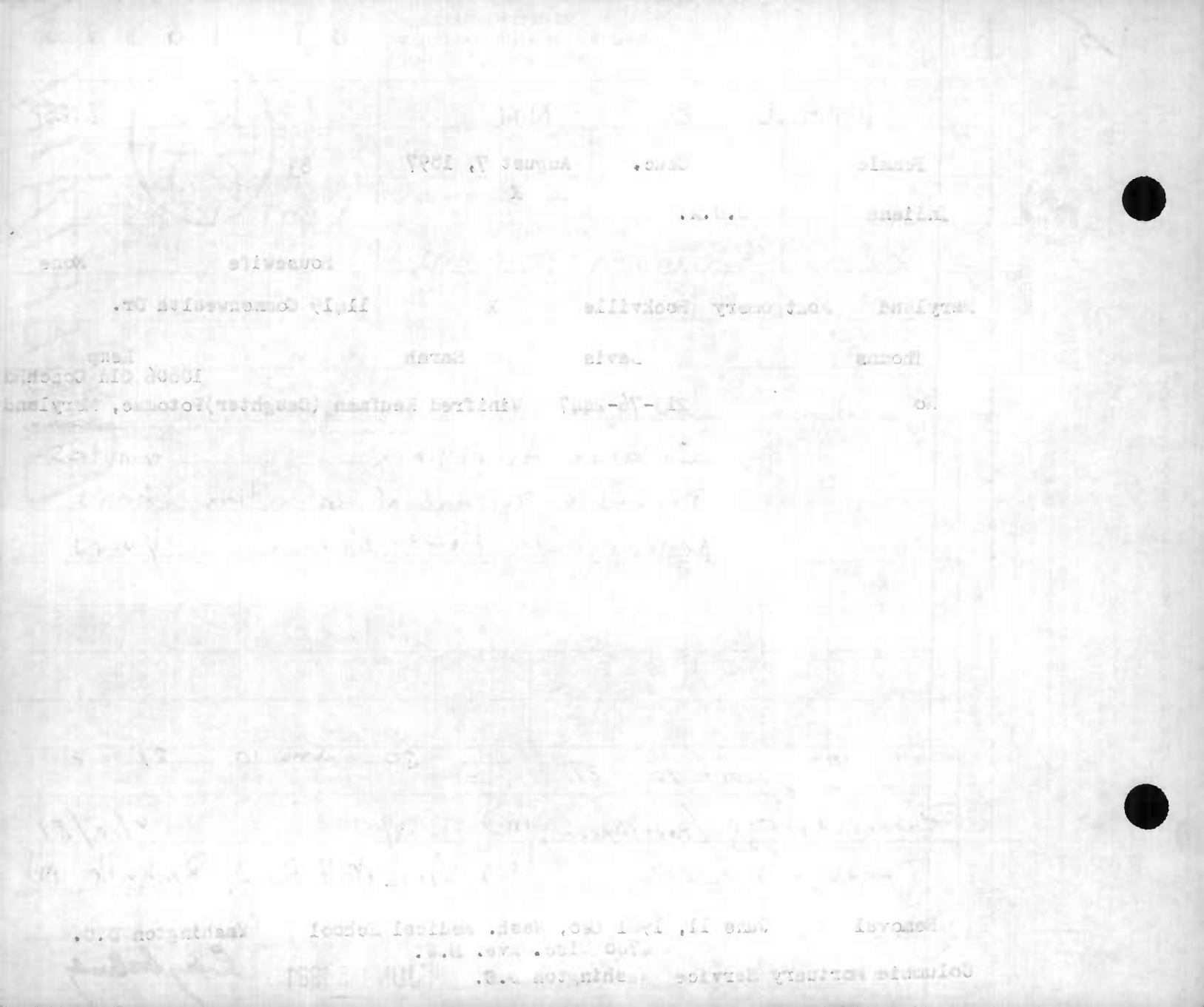
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |   |  |  |  |  |  |
|--|--|---|--|---|--|--|--|--|--|
| FOR<br>1 - STATE<br>REGISTRAR  |  |   |  |   | REG. NO. 8 1 1 6 3 9 5   |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   |  |   | 2a. DATE OF DEATH  |  |  | 2b. HOUR   |  |
| FIRST MIDDLE LAST<br>Winifred E. Nine  |  |   |  |   | MONTH DAY YEAR<br>6-10-81  |  |  | 2:25 PM  |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                  |  | 7. IF UNDER 1 YEAR   |  |
| Female   |  | Cauc.   |  | MONTH DAY YEAR<br>August 7, 1897  |  | 83 YRS.  |  | IF UNDER 24 HRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                             |  |  |  |
| Indiana  |  | U.S.A.  |  |   |  | Montgomery MD  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| Bethesda   |  | Suburban Hospital   |  |   |  | Housewife  |  | None   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS  |  |  |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br>Maryland Montgomery Rockville  |  |   |  |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 11419 Commonwealth Dr.   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Thomas Davis   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Sarah Kemp                    |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |  |   |  |   | 16b. SOCIAL SECURITY NO.<br>215-76-2447  |  | 17. INFORMANT ADDRESS<br>Winifred Kaufman (Daughter) Potomac, Maryland |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiac Arrhythmia<br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Probable myocardial infarction<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Arteriosclerotic Heart Disease |  |   |  |   |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>minutes<br>hours<br>years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |   |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>         |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |  |
| 22a. I certify that (this Hospital) attended the deceased from 19 80, to June 10, 19 81, that I (we) last saw the deceased alive on June 10, 19 81, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) did not view the body after death.)         |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br>Patricia Kellogg / Robt Macan  |  |   |  |   | DEGREE<br>M.D.   |  | 22c. DATE SIGNED<br>6/10/81  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>PATRICIA KELLOGG  |  |   |  |   | 22e. ADDRESS<br>809 Viers Mill Road, Rockville; md                             |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  |   | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                             |  |  |
| Removal  |  |   | June 11, 1981  |   | Geo. Wash. Medical School  |  | Washington D.C.  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Columbia Mortuary Service Washington D.C.  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE<br>Ruthy Brady                              |  |  |
|  |  |   |  |   | JUN 15 1981  |  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8 1 1 6 3 9 6   |  |   |   |
|---|--|---|--|---|--|---|---|
| 1. FOR<br>STATE<br>REGISTRAR  |  |   |  | CERTIFICATE OF DEATH  |  |   |   |
| I. DECEASED NAME<br>(TYPE OR PRINT)   |  |   |  | 2a. DATE OF DEATH   |  |   |   |
| MARION S. NIVEN   |  |   |  | June 24/81  |  |   |   |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>CAUCASIAN  |  | 5. DATE OF BIRTH<br>Jan. 4 1889   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Ohio   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Mont.   |   |
| 10. CITY OR TOWN OF DEATH<br>Rockville  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Potomac Valley Nsg. Home |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  | 13d. INSIDE CITY LIMITS?  |  |   |   |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Mont.  |  | 13c. CITY OR TOWN<br>Chevy Chase  |  | 13d. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |
| 14. FATHER'S NAME<br>George P. Squier   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>Carey Ellen Saxton  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>065-52-6128  |  | 17. INFORMANT<br>3302 Brooklawn Terr. Chevy Chase, Md.<br>Ellen Jean Carlson (Daughter) 20015   |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>4360 IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Arteriosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Senility</u>                  |  |   |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>3 days<br>plus<br>11 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |   |  |   |  |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |   |   |
| 22a. I certify that (i) (this hospital) attended the deceased from <u>Oct 76</u> to <u>6/24/81</u> that (i) (we) last saw the deceased alive on <u>6/23/81</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (i) (we) (did not) view the body after death. |  |   |  |   |  |   |   |
| 22b. SIGNATURE<br>Thos G. WARD  |  | DEGREE<br>MD  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br>6/24/81   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Thos G. WARD   |  | 22e. ADDRESS<br>6116 Robinson Bethesda, Md.   |  |   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>June 26, 1981  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Forest Lawn Cemetery  |  | 23d. LOCATION<br>Erie City Buffalo New York STATE   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>316   |  | Gartner-Sandison Funeral Home<br>East Diamond Ave. Gaithersburg, Md.  |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 30 1981  |  | 25b. REGISTRAR'S SIGNATURE  |   |

MEDICAL CERTIFICATION





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD WRITE "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL EXAMINER. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17  
(VR 115 ME (5))  
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |
|--|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 16397   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | 2a. DATE KNOWN OF DEATH   |  |
| George Todd Norris   |  | 6/15 19 81  |  |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH  | 6. AGE (IN YEARS)  |
| Male   | White  | Dec. 20, 1911   | 69 YRS.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH   |
| Ohio   | USA  |   | Montgomery County MD.  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   | 12b. KIND OF BUSINESS OR INDUSTRY  |
| Silver Spring  | 201 University Boulevard West  | Electronics   | NSA  |
| 13a. STATE   | 13b. COUNTY  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| Maryland   | Montgomery   | Silver Spring   | 201 University Boulevard West  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |  |
| John Howard Norris   | Anna Mary Leathers   | yes WW1   |  |
| 16b. SOCIAL SECURITY NO.   | 17. INFORMANT  | 17. ADDRESS   |  |
| 578-38-3483  | Nell W. Norris-wife-(same as 13e)  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute myocardial disease.</u><br>4391<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>None   |  |   |  |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  | 20. AUTOPSY?  |  |
| None   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |
|  |  | None  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |
| ACTUAL SIGNATURE<br><i>John S. Rogers</i>  |  | TITLE (SPECIFY)<br>M.D. Deputy MEDICAL EXAMINER   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>John S. Rogers, M.D.   |  | DATE SIGNED<br>6/15/81  |  |
| ADDRESS<br>1919 Seminary Road<br>Silver Spring, Montgomery, Md.  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |
| Cremation  | 6-16-81  | Metropolitan Crematory Alex.  | Alexandria Va.   |
| 24. FUNERAL DIRECTOR<br>Warner E. Pumphrey, Inc.   |  | 25a. DATE REC'D. BY REGISTRAR   |  |
| 8434 Ga. Ave., S.S. Md.  |  | JUN 18 1981   |  |
|  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Anthony McBrady</i>  |  |

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XXL 41 170/180

DATE: 11.11.1961

TO: Mr. J. B. ...

FROM: Mr. J. B. ...

SUBJECT: ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-1350.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |   |  |   |                      |  |  |
|---|--|--|--|---|--|---|----------------------|--|--|
| 1- FOR STATE REGISTRAR  |  |  |  |   | 8 1 1 6 3 9 8  |   |                      |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  |   | 2a. DATE OF DEATH  |   |                      |  |  |
| FIRST MIDDLE LAST   |  |  |  |   | MONTH DAY YEAR HOUR  |   |                      |  |  |
| KARL H. NOYES   |  |  |  |   | 06:12:81 10:00AM   |   |                      |  |  |
| 3 SEX   |  | 4 RACE   |  | 5. DATE OF BIRTH  |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                      |                      | IF UNDER 1 YEAR  |  |
| MALE  |  | WHITE  |  | MONTH DAY YEAR  |  | 57  |                      | MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |                      |  |  |
| WASH. D.C.  |  | U.S.A.   |  |   |  | MONTGOMERY CO. MD.  |                      |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |                      | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| Silver Spring   |  | Holy Cross Hosp  |  |   |  | Cout  |                      | ELECTRONICS  |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |                      | 13e. STREET ADDRESS  |  |
| MD  |  | Mont.  |  | Silver Spring   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                      | 1715 Cody Dr.  |  |
| 14. FATHER'S NAME   |  |  |  |   | 15. MOTHER'S MAIDEN NAME   |   |                      |  |  |
| FIRST MIDDLE LAST   |  |  |  |   | FIRST MIDDLE LAST  |   |                      |  |  |
| KARL H. NOYES SR.   |  |  |  |   | MARGARET KRAUS   |   |                      |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)  |  |  |  |   | 16b. SOCIAL SECURITY NO.   |   | 17 INFORMANT ADDRESS |  |  |
| YES   |  |  |  |   | WW II  |   | 816-38-2881          |  |  |
|   |  |  |  |   | EDWARD NOYES   |   |                      | 1715 CODY DR. SILVER SPR., MD.                                 |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)   |  |  |  |   |  |   |                      |  |  |
| PART I. DEATH WAS CAUSED BY   |  |  |  |   |  |   |                      |  |  |
| IMMEDIATE CAUSE (a) Respiratory Failure   |  |  |  |   |  |   |                      |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |  |   |                      |  |  |
| (b) Lung Cancer   |  |  |  |   |  |   |                      |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |  |   |                      |  |  |
| (c)   |  |  |  |   |  |   |                      |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |  |  |   |  |   |                      |  |  |
| Hepatic metastasis  |  |  |  |   |  |   |                      |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?   |                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |  |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                      | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |                      |  |  |
|   |  | HOUR A.M. MONTH DAY YEAR   |  |   |  |   |                      |  |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION   |  |   |                      |  |  |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  |  | STREET CITY OR TOWN COUNTY STATE  |  |   |                      |  |  |
| 22a. I certify that (a) (this hospital) attended the deceased from 10 19 80 to 6 19 81, that (b) (we) lost saw the deceased alive on 6/11 19 81, and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above (a) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |                      |  |  |
| 22b. SIGNATURE  |  |  |  |   | DEGREE   |   |                      | 22c. DATE SIGNED   |  |
| Peter B. Sherer MD  |  |  |  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |                      | 6/12/81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  |   | 22e. ADDRESS   |   |                      |  |  |
| PETER B. SHERER MD  |  |  |  |   | 1109 Spring St. #60 Silver Spring MD   |   |                      |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION   |                      |  |  |
| CREMATION   |  | 6-15-1981  |  | CEDAR HILL CREM.  |  | SUITLAND PG.C. MD.  |                      |  |  |
| 24 FUNERAL DIRECTOR   |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR  |   |                      |  |  |
| W.W. CHAMBERS Co Inc. SIL. SPR. MD.   |  |  |  |   | JUN 19 1981  |   |                      |  |  |
| 25b. REGISTRAR'S SIGNATURE  |  |  |  |   |  |   |                      |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |   |   |   |  |  |  |
|--|--|--|--|---|---|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   | 8 1 1 6 3 9 9   |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  |   | 2a. DATE OF DEATH                                     |   |  |  |  |
| FIRST MIDDLE LAST<br><b>BERNARD ISAAC NUMKIN</b>   |  |  |  |   | MONTH DAY YEAR<br><b>JUNE 13 1981</b>                 |   |  |  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |   | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | 7b. HOUR   |  |
| <b>Male</b>  |  | <b>CAUCASIAN</b>   |  | MONTH DAY YEAR<br><b>MARCH 12, 1911</b>   |   | <b>70</b> YRS.  |  | <b>11:17 A.M.</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |
| <b>MARYLAND</b>  |  | <b>USA</b>   |  |   |   | <b>MONTGOMERY MD.</b>   |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| <b>SILVER SPRING</b>   |  | <b>HOLY CROSS HOSPITAL</b>   |  |   |   | <b>SALESMAN</b>   |  | <b>RETAIL SHOES</b>  |  |
| 13a. STATE   |  |  |  |   | 13b. CITY OR TOWN                                     |   | 13c. STREET ADDRESS                                    |  |  |
| <b>MARYLAND</b>  |  |  |  |   | <b>MONTGOMERY</b>                                     |   | <b>SILVER SPRING</b>                                   |  |  |
| 14. FATHER'S NAME  |  |  |  |   | 15. MOTHER'S MAIDEN NAME                              |   |  |  |  |
| FIRST MIDDLE LAST<br><b>LOUIS --- NUMKIN</b>   |  |  |  |   | FIRST MIDDLE LAST<br><b>ESTHER --- SAVAL</b>          |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |  |  |  |   | 16b. SOCIAL SECURITY NO.                              |   | 17. INFORMANT ADDRESS                                  |  |  |
| <b>NO</b>  |  |  |  |   | <b>577-05-2857</b>                                    |   | <b>LOUIS NUMKIN (SON) 2712 FINCH ST. SIL. SPR. MD.</b> |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |  |  |   |   |   |  |  |  |
| PART 1. DEATH WAS CAUSED BY:   |  |  |  |   |   |   |  |  |  |
| IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b>  |  |  |  |   |   |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |   |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |   |   |   |  |  |  |
| (b) _____  |  |  |  |   |   |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |   |   |  |  |  |
| (c) _____  |  |  |  |   |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |  |  |   |   |   |  |  |  |
| <b>CARCINOMA OF STOMACH WITH HEPATIC METASTASES - THROMBOCYTOPENIA</b>   |  |  |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |   | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |  |  |   |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |  |  |  |
|  |  | HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  |   |   |   |  |  |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)  |  | 21f. LOCATION   |   |   |  |  |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  |  | STREET CITY OR TOWN COUNTY STATE  |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19 <b>70</b> , to <b>JUNE 13</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>JUNE 9</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |   |  |  |  |
| 22b. SIGNATURE   |  |  |  |   | DEGREE  |   |  | 22c. DATE SIGNED   |  |
| <b>Robert A. Krichmar</b>  |  |  |  |   | <b>MD</b>   |   |  | <b>JUNE 14 1981</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  |   | 22e. ADDRESS  |   |  |  |  |
| <b>ROBERT A. KRICHMAR MD</b>   |  |  |  |   | <b>7733 ALASKA AVENUE N.W. WASHINGTON, D.C. 20012</b> |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION   |  |  |  |
| <b>BURIAL</b>  |  | <b>6/16/81</b>   |  | <b>MT. LEBANON MEM. PARK</b>  |   | <b>HYATTSVILLE, MD</b>  |  |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  |   | 25. DATE REC'D BY REGISTRAR                           |   |  |  |  |
| <b>DANZANSKY-GOLDBERG MEM. CH., 1170 ROCKVILLE PIKE</b>  |  |  |  |   | <b>ROCKVILLE, MD. JUN 17 1981</b>                     |   |  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 81216400  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR 6 5 81 2b. HOUR 1.25 M  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) Charles E. O'Hara   |  |  |  | 2b. DATE OF DEATH MONTH DAY YEAR 6 5 81 2b. HOUR 1.25 M  |  |   |  |
| 3. SEX Male  |  | 4. RACE White  |  | 5. DATE OF BIRTH MONTH DAY YEAR 04 29 1903   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.   |  |
| 10. CITY OR TOWN OF DEATH Bethesda   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Govt. Employee   |  | 12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Kensington   |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Edward - O'Hara  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carolyn - (Unavailable)   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) No  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) - 568 10 7981   |  | 17. INFORMANT Wife   |  | ADDRESS Same as #13   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 Cardiac Arrest  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Due to, OR AS A CONSEQUENCE OF Coronary Heart Disease   |  |  |  |  |  |   |  |
| (c) Due to, OR AS A CONSEQUENCE OF Myocardial Infarction   |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from May 31, 19 81 to June 5, 19 81, that (I) (we) last saw the deceased alive on June 5, 19 81 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If two or more physicians did not view the body after death) |  |  |  |  |  |   |  |
| 22b. SIGNATURE (Type or Print) Boo K. Kim  |  |  |  | 22c. DATE SIGNED 6/5/81  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Boo K. Kim  |  |
| 22e. ADDRESS 16220 Frederic Rd, Gaith, Md.   |  |  |  | 22f. DATE REC'D. BY REGISTRAR JUN 10 1981  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL   |  | 23b. DATE June 8 1981  |  | 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Wheaton Montgomery Md.  |  |
| 24. FUNERAL DIRECTOR (NAME) DeVol Funeral Home   |  |  |  | 25. REGISTRAR'S SIGNATURE  |  |   |  |
| ADDRESS 2222 Wisc Ave. Washington D.C.   |  |  |  | 25. REGISTRAR'S SIGNATURE  |  |   |  |

1202



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| FOR<br>STATE<br>REGISTRAR  |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO.<br>8116401  |  |   |  |
|--|--|---|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ELEANOR E. OMOHUNDRO  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>6 9 81   |  |  |  | 2b. HOUR<br>5:30 AM  |  |   |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>CAUCASIAN  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>JULY 7, 1922  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>58 YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN.           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>PENNSYLVANIA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY MD.                               |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>SILVER SPRING   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>902 HELENA DRIVE |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>ANALYST          |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>FEDERAL RESERVE BD.   |  |   |  |
| 13a. STATE<br>MARYLAND   |  |   |  | 13b. COUNTY<br>MONTGOMERY   |  | 13c. CITY OR TOWN<br>SILVER SPRING   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET ADDRESS<br>902 HELENA DRIVE |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>EDGAR H. OMOHUNDRO   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>CLARA E. WARNESON  |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>577-22-8974   |  | 17. INFORMANT<br>PATRICIA McSHANE   |  |  |  | ADDRESS<br>SAME AS 13 FRIEND   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1: DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Pulmonary + CARDIAC Arrest</u><br>1830<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Carcinoma</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>CANCER of Ovary</u> |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>24 hr<br>6 Months<br>6-8 MO.   |  |   |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>None</u>   |  |   |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION<br>4/31/81  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>CANCER of ovary   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/15</u> 19 <u>74</u> , to <u>5/18</u> 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>6/14</u> 19 <u>81</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><u>Max G. Shener MD</u>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |  |  | 22c. DATE SIGNED<br>6/21/81  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MAX G. SHENER MD  |  |   |  | 22e. ADDRESS<br>600 Pershing Drive Silver Spring, Md 20901  |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b. DATE<br>6/12/81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>COLUMBIA GARDENS  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>ARLINGTON VIRGINIA                     |  |  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>FRANCIS J. COLLINS   |  |   |  | 25a. DATE REC'D BY REGISTRAR<br>JUN 12 1981   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Jeffrey H. Harty</u>  |  |   |  |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901  |  |   |  |   |  |  |  |  |  |   |  |

10-0

18

STANDARD TIME

10-0

10-0



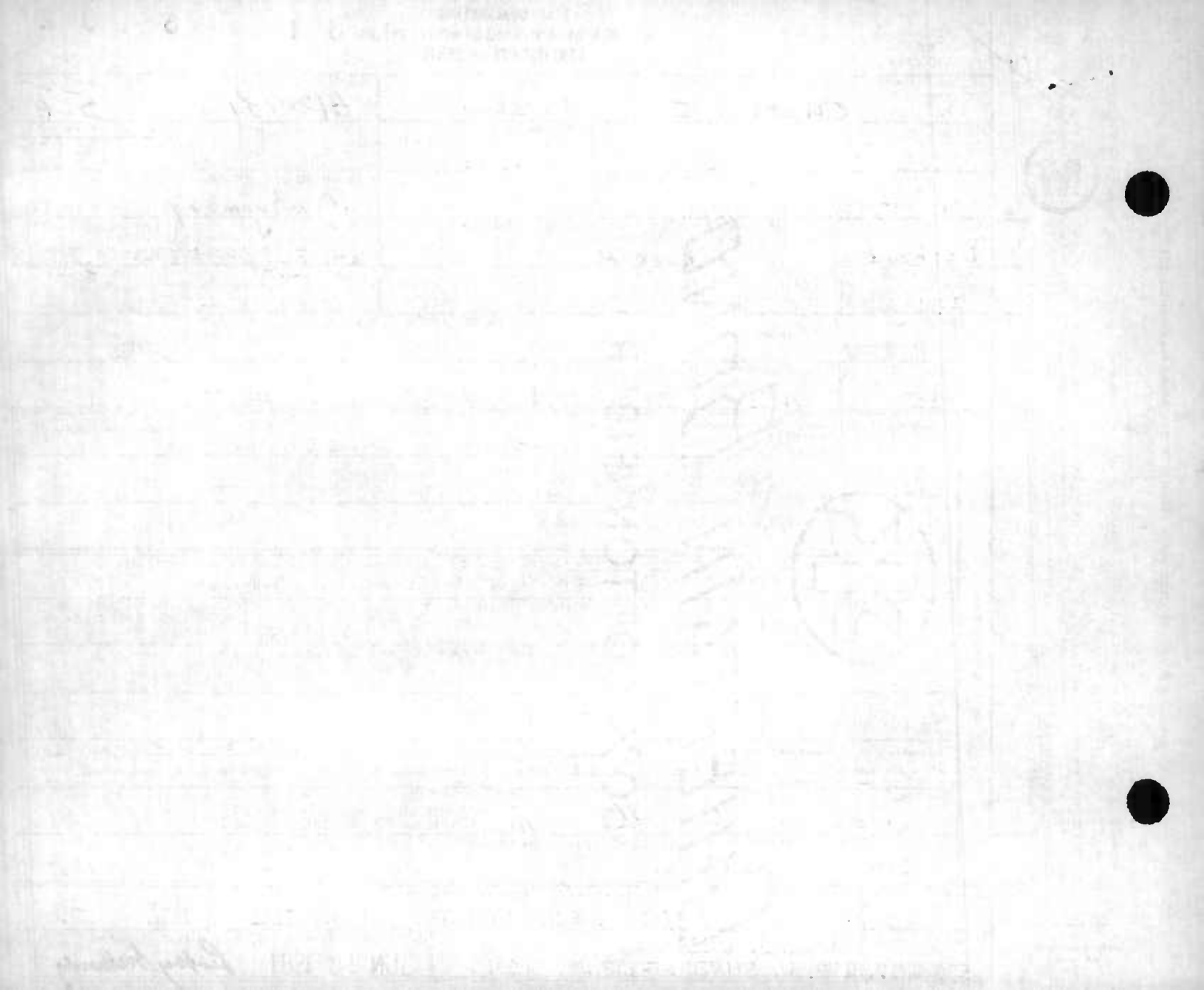
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |   |   |  |  |  |  | 8  | 1 | 1   | 6 | 4                            | 0 | 2 |
|--|--|--|--|---|---|--|--|--|--|--|---|---|---|------------------------------|---|---|
| CERTIFICATE OF DEATH   |  |  |  |   |   |  |  |  |  | REG. NO.   |   |   |   |                              |   |   |
| 1. DECEASED NAME<br>(Type or Print) <b>CHARLES J. O'STEEN</b>  |  |  |  |   |   |  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4/20/81</b>  |   |   |   | 2b. HOUR<br><b>5:30 P.M.</b> |   |   |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>CAUCASIAN</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>OCT 1, 1925</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>55</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  | IF UNDER 24 HRS.   |   |   |   |                              |   |   |
| 7a. BIRTHPLACE<br>(State or Foreign Country)<br><b>NORTH CAROLINA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                  |  |  |  |  |   |   |   |                              |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(If not in such facility, give street address)<br><b>Suburban</b> |  |   |   | 12a. USUAL OCCUPATION<br>(Type of work for most of working life)<br><b>CHIEF OF OPERATIONS</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>USDA AREA</b>  |  |  |   |   |   |                              |   |   |
| USUAL RESIDENCE (If nursing home or other institution, give residence before admission)<br>13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>FREDERICK</b> 13c. CITY OR TOWN <b>FREDERICK</b>  |  |  |  |   |   |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 13e. STREET ADDRESS<br><b>8206 MORNING DEW LANE</b> |   |                              |   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>HERBERT O'STEEN</b>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>JANIE JONES</b> |  |  |  |  |  |   |   |   |                              |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>YES</b>  |  | 16b. SOCIAL SECURITY NO.<br>(If yes, give war or dates) <b>WW II</b>   |  | 17. INFORMANT<br><b>RUBY W. O'STEEN</b>   |   | ADDRESS<br><b>SAME AS 13</b>   |  | WIFE   |  |  |   |   |   |                              |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b><br><b>7103</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>DERMATOMYOSITIS</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |   |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>WEEKS</b>   |   |   |   |                              |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>IDIOPATHIC PULMONARY FIBROSIS yrs</b>  |  |  |  |   |   |  |  |  |  |  |   |   |   |                              |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |   |   |   |                              |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in item 18, Part I or Part 2)  |   |  |  |  |  |  |   |   |   |                              |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(At home, street, factory, office, farm, etc.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |  |  |   |   |   |                              |   |   |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>JUNE 1979</b> to <b>JUNE 20, 1981</b> , that (I) (we) last saw the deceased alive on <b>8/20</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.  |  |  |  |   |   |  |  |  |  |  |   |   |   |                              |   |   |
| 22b. SIGNATURE<br><b>Daniel Rosenblum</b>  |  |  |  | DEGREE<br><b>MD</b>   |   |  |  | 22c. DATE SIGNED<br><b>6/20/81</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   |   |                              |   |   |
| 22d. PHYSICIAN'S NAME (Type or Print)<br><b>DANIEL ROSENBLUM</b>   |  |  |  | 22e. ADDRESS<br><b>10400 CONNECTICUT AVE<br/>KENSINGTON, MD 20795</b>   |   |  |  |  |  |  |   |   |   |                              |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(Specify)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>6/24/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>PARKLAWN CEMETERY</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ROCKVILLE MONT MD.</b>                        |  |  |  |  |   |   |   |                              |   |   |
| 24. FUNERAL DIRECTOR<br>NAME <b>FRANCIS J. COLLINS</b> ADDRESS<br><b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>   |  |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 22 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Dorothy K. H. H.</b>  |  |  |   |   |   |                              |   |   |



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |   |  |                                   |
|---|--|---|---|--|-----------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Joseph J. Oulahan</b>   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>6 26 81</b>  |  | 2b. HOUR<br><b>2:20</b> M         |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>8 7 98</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Washington, D.C.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.                                   |  |                                   |
| 10. CITY OR TOWN OF DEATH<br><b>Rockville</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Collingswood Hosp. Home, 299 Hurley Ave</b> |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>THEATER EXHIBITOR</b>       |  | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE<br><b>Maryland</b>   | 13b. COUNTY<br><b>Montgomery</b>   | 13c. CITY OR TOWN<br><b>Rockville</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>Bethesda, Md. 20034</b><br><b>2505 Democracy Blvd.</b>     |                                   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>JOSEPH F. OULAHAN</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>LOUISE GRAFF</b>   |   |  |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>YES</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>WW I</b>   | 17. INFORMANT ADDRESS<br><b>ANNA MAHER OULAHAN SAME AS 13 WIFE</b>                              |  |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary Embolus</b><br><b>4151</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____        |  |   |   |  |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Cancer of the Prostate</b>   |  |   |   |  |                                   |
| 19a. DATE OF OPERATION<br><b>9-28-77</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)      |                                   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                       |                                   |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>9-28-77</b> , 19 <b>81</b> , to <b>June 21</b> , 19 <b>81</b> , that (1) (we) last saw the deceased alive on <b>May 28</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. |  |   |   |  |                                   |
| 22b. SIGNATURE<br><b>F. C. Blackburn</b>  |  | DEGREE  |   | 22c. DATE SIGNED<br><b>June 26 1981</b>  |                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>F. C. BLACKBURN</b>   |  | 22e. ADDRESS<br><b>5401 Western Ave Wash DC 20015</b>   |   |  |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  | 23b. DATE<br><b>6/29/81</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT. OLIVET CEMETERY</b>  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>WASHINGTON, D. C.</b>                  |                                   |
| 24. FUNERAL DIRECTOR NAME<br><b>FRANCIS J. COLLINS</b>  |  | 25a. DATE RECEIVED BY REGISTRAR<br><b>JUN 30 1981</b>   |   | 25b. REGISTERING SIGNATURE<br><b>Robert J. [Signature]</b>                           |                                   |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901   |  |   |   |  |                                   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 410-388-1111.





*Handwritten signature or name.*

JUN 3 1901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

DHMH-16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |  |  |   |  |  |  |
|---|--|--|--|--|--|---|--|--|--|
| 1- FOR<br>STATE<br>REGISTRAR  |  | 8 1 1 6 4 0 4  |  |  |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br>DOLORES   |  | LAST<br>PALACIOS   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>6/1/1981                                  |  | 2b. HOUR<br>10:14 AM   |  |
| 3 SEX<br>FEMALE   |  | 4 RACE<br>White  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>3 23 1912  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>69 YRS                                      |  | 7 UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Nicaragua  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>Nicaragua  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD                          |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>TAKOMA PK.   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>WASHINGTON ADVENTIST H.                 |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home  |  |
| 13a. STATE<br>D.C.  |  | 13b. CITY OR TOWN<br>Washington  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br>1531 Spring Pl. N.W.                                   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Rosendo Casdlo   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Modesta Palacios   |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>579-64-8793   |  | 17 INFORMANT ADDRESS<br>Roger R Palacios, Son. Same as item 13   |  |   |  |  |  |
| 18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>4300 IMMEDIATE CAUSE (a) Cardio-respiratory arrest.<br>DUE TO, OR AS A CONSEQUENCE OF (b) Aspiration / pneumonia<br>(c) Subarachnoid hemorrhage  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from May 30 1981 to June 1 1981, that (I) (we) last saw the deceased alive on May 30 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br>Miguel A. Rodriguez   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |  | 22c. DATE SIGNED<br>6/1/1981  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MIGUEL A. RODRIGUEZ  |  | 22e. ADDRESS<br>8634 Flower Ave. T. Park   |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>6/6/1981  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Norbeck Memorial Gardens   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Silver Spring, Md.              |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Joseph Gawler's Sons, Inc.<br>5130 Wisc. Ave., N.W. Wash., D.C.   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 5 1981  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]                                     |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |   |  |   |  |  |  | 8   | 1 | 6 | 4 | 0 | 5 |
|--|--|---|--|---|--|---|--|--|--|---|---|---|---|---|---|
| 1. FOR STATE REGISTRAR   |  |   |  |   |  |   |  |  |  | REG. NO.  |   |   |   |   |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JOSEPHINE SPARKS PEYTON</b>   |  |   |  |   |  |   |  |  |  | 2a. DATE OF DEATH<br>MONTH <b>6</b> DAY <b>13</b> YEAR <b>81</b> HOUR <b>9</b> AM |   |   |   |   |   |
| 3 SEX<br><b>FEMALE</b>   |  | 4 RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>11</b> DAY <b>15</b> YEAR <b>11</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>   |  | IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b>                                    |   |   |   |   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Washington, D.C.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County</b> MD.                      |  |  |  |   |   |   |   |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SUBURBAN HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret. Secretary</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Gov't.</b>  |  |   |   |   |   |   |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE <b>M'D</b> 13b. COUNTY <b>MONT.</b> 13c. CITY OR TOWN <b>ROCKVILLE</b> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |   |  |   |  |  |  | 13e. STREET ADDRESS<br><b>11418 GRAYLING LANE</b>                                 |   |   |   |   |   |
| 14. FATHER'S NAME<br>FIRST <b>Charles</b> MIDDLE <b>Allen</b> LAST <b>Sparks</b>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Cora</b> MIDDLE <b>T.</b> LAST <b>May</b> |   |  |  |  |   |   |   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES) <b>None</b>   |  | 17. INFORMANT<br><b>Edgar C. Peyton</b>   |  | ADDRESS<br><b>Same as item 13e</b>  |  |  |  |   |   |   |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Acute M.I.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b>                              |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b></b>                           |   |   |   |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>   |  |   |  |   |  |   |  |  |  |   |   |   |   |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |   |   |   |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |   |   |   |   |   |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |   |   |   |   |   |   |
| 22a. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>6/11</b> , 19 <b>81</b> , to <b>6/13</b> , 19 <b>81</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>6/11/81</b> , 19 <b></b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) (did not) view the body after death. |  |   |  |   |  |   |  |  |  |   |   |   |   |   |   |
| 22b. SIGNATURE<br><b>Carol L. Bender</b> DEGREE <b>Bender</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |   |  |   |  | 22c. DATE SIGNED<br><b>6/13/81</b>  |  |  |  |   |   |   |   |   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Carol L. Bender</b>  |  |   |  |   |  | 22e. ADDRESS<br><b>11125 Rockville Pike Rockville, Md.</b>                                |  |  |  |   |   |   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>6/16/81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parklawn Mem. Park</b>   |  | 23d. LOCATION<br>CITY OR TOWN <b>Rockville</b> COUNTY <b>Montgomery</b> STATE <b>Md.</b>  |  |  |  |   |   |   |   |   |   |
| 24. FUNERAL DIRECTOR<br>NAME <b>Tyson Wheeler Funeral Home, Inc.</b> ADDRESS <b>1331 Rockville Pike Rockville, Md.</b>   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 17 1981</b>                                       |  | 25b. REGISTRAR'S SIGNATURE<br><b></b>  |  |   |   |   |   |   |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |   |  |  | REG. NO.  |   |  |
|--|--|--|--|---|--|--|---|--|--|---|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   | 2a. DATE OF DEATH  |  |   |  |  | 2b. HOUR  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>GEORGE E. PIERCE</b>  |  |  |  |   | June 29 1981   |  |   |  |  | 3:05P <sup>M</sup>  |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Caucasian</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Oct. 13<sup>AY</sup> 1909</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b>   |   | IF UNDER 1 YEAR MONTHS DAYS  |  | IF UNDER 24 HRS. HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Panama Canal</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                              |   |  |  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>National Naval Medical Center</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>U. S. Navy Officer</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Navy</b>  |  |   |   |  |
| 13a. STATE<br><b>Maryland</b>  |  |  |  |   | 13b. COUNTY<br><b>Montgomery</b>   |  | 13c. CITY OR TOWN<br><b>Bethesda</b>                            |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>5416 Lambeth Road</b> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Claude Connor Pierce</b>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Tamar Reeves</b>        |  |   |  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>Yes</b>  |  |  |  |   | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br><b>1928/1959</b> |  | 17. INFORMANT ADDRESS<br><b>Mrs. Mary M. Pierce See item 13</b> |  |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Oat cell carcinoma of the lung</b><br>1629<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |  |   |  |  |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____  |  |  |  |   |  |  |   |  |  |   |   |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |   |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |   |  |
| 22a. I certify that I (this hospital) attended the deceased from <b>June 2</b> , 19 <b>81</b> , to <b>June 29</b> , 19 <b>81</b> , that I (we) last saw the deceased alive on <b>June 29</b> , 19 <b>81</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |   |  |  |   |   |  |
| 22b. SIGNATURE<br><b>Carl H. June M.D.</b>   |  |  |  |   |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>June 29, 1981</b>  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Carl H. June, M.D.</b>   |  |  |  |   |  |  |   | 22e. ADDRESS<br><b>National Naval Medical Center, Bethesda, Md.</b>  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |  |  | 23b. DATE<br><b>7/2/1981</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National</b>                            |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Arlington Arlington Va.</b>  |  |   |   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Joseph Gawler Sons</b>   |  |  |  | 5130 Wisc. Ave., N.W.<br>Washington, D.C.   |  |  |   | 25. DATE RECD. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>JUL 6 1981</b> <i>Jeffrey Hubbard</i>   |  |   |   |  |

100-100000-100000

100-100000-100000

100-100000-100000



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITH THE VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17  
(VR A15 ME (1))  
15M 2/80

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                  |  |  |  |   |  |  |  | REG. NO. 16407 |  |
|--|--|------------------|--|--|--|---|--|--|--|----------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Lyndz ANN Jones Pirkle</b>  |  |                  |  |  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input type="checkbox"/> MONTH DAY YEAR <b>June 27 1981</b>  |  | 2b. HOUR <b>2:30 PM</b>  |  |                |  |
| 3. SEX <b>F</b>  |  | 4. RACE <b>W</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>Nov. 19 1945</b>   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>36 YRS.</b>   |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN.  |  |                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Delaware</b>  |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b>   |  |                |  |
| 10. CITY OR TOWN OF DEATH <b>Sil. Spg</b>  |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3142 Hewitt Ave, Apt 12A</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk</b>                     |  |                |  |
| 13a. STATE <b>MD</b>   |  |                  |  | 13b. COUNTY <b>Montg</b>   |  | 13c. CITY OR TOWN <b>Sil. Spg</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Edgar Marvin Jones</b>   |  |                  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Clara Belle Ellis</b>   |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Dept. of Defense</b>                                      |  |                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>No</b>  |  |                  |  | 16b. SOCIAL SECURITY NO. <b>222-28-9729</b>  |  | 17. INFORMANT <b>J. Donovan Pirkle</b> husband same as 13   |  |  |  |                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Gun shot &amp; wound of chest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>None</b> |  |                  |  |  |  |   |  |  |  |                |  |
| 19a. DATE OF OPERATION <b>None</b>   |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |                |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>2006 PM 6 21 1981</b>  |  |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR <b>2006 PM 6 21 1981</b>   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>Shot self</b> |  |                |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Home</b>  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE <b>Hewitt Ave, Sil. Spg, Montg, MD</b>  |  |  |  |                |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .   |  |                  |  |  |  |   |  |  |  |                |  |
| ACTUAL SIGNATURE <b>John S. Rogers</b>   |  |                  |  | TITLE (SPECIFY) <b>MD</b>  |  |   |  | DATE SIGNED <b>June 27 1981</b>  |  |                |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers, M.D.</b>  |  |                  |  | ADDRESS <b>1919 Seminary Road Silver Spring, Md.</b>   |  |   |  |  |  |                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  |                  |  | 23b. DATE <b>Jun. 30, 1981</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>St. Mark's Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Laural Delmar Delaware</b>                       |  |                |  |
| 24. FUNERAL DIRECTOR NAME <b>Francis J. Collins</b>  |  |                  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>JUN 30 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Anthony...</b>   |  |                |  |
| 26. FUNERAL HOME ADDRESS <b>500 University Blvd., W. Silver Spring, Md.</b>  |  |                  |  |  |  |   |  |  |  |                |  |

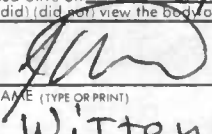
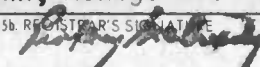
0200-00-000

THE TCMU

## CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |   |  |   |  |  |  |  |  |  |
|--|--|---|--|---|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>HOWARD PLUMMER</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JUNE 2, 1981</b>               |   |  | 2b. HOUR<br>MIN<br><b>8:02AM</b>   |  |  |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>BLACK</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>08 22 19</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>61</b> YRS   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>OLNEY</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MONTGOMERY GENERAL HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a. STATE<br><b>MARYLAND</b>  |  |   | 13b. COUNTY<br><b>MONTG.</b>   |   | 13c. CITY OR TOWN<br><b>DAMASCUS</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>27504 RIDGE ROAD</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>HARRY PLUMMER</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>LOTTIE SMITH</b>     |   |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  |   | 16b. SOCIAL SECURITY NO.<br><b>217-32-0061</b>                           |   | 17. INFORMANT<br>ADDRESS<br><b>Maude Plummer (wife) same as #13</b>            |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Alzheimer's Disease</u><br><b>3310</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>5 years</u>   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                         |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19               |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May 7</u> , 19 <u>81</u> , to <u>6/1</u> , 19 <u>81</u> , that (I) (we) lost<br>saw the deceased alive on <u>6/1</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |  |  |  |
| 22b. SIGNATURE<br>  |  |   | DEGREE   |   |  | ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/><br>PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><u>6/2/81</u>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Wittenborn</b>   |  |   | 22e. ADDRESS<br><b>4822 Mac A. Thur Blvd. Wash DC</b>                    |   |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>6-6-81</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Poplar Grove Cem.</b>                 |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Darnestown, Montg. Md.</b>          |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>George R. Snowden</b>   |  |   | 24b. ADDRESS<br><b>246 N. Washington Street<br/>Rockville, Md. 20850</b> |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 5 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE<br>        |  |  |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

81

NO 327-32-0001 | Manda Plummer (wife) born in 1913

*W. T. Plummer*

1913

1913

W. T. Plummer

W. T. Plummer, 1913

W. T. Plummer, 1913

1913

1913

346 N. Harrison Street  
Rochester, N.Y. 14602

George R. Sanden  
Rochester, N.Y. 14602

July 1, 1913

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |   |   |   | 8 1 1 6 4 0 9   |  |
|---|---|---|---|---|--|
| 1. FOR STATE REGISTRAR  |   |   |   | REG. NO.  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Thomas H. Podelco</b>   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>June 29 1981</b>       |   | 2b. HOUR<br><b>11:30 P.M.</b>  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>Caucasian</b>   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Jan. 29, 1923</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>58</b> YRS.             | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>West Virginia</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery MD.</b> |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>4740 Bradley Blvd. (A-9)</b> | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>INDUSTRY</b>  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>SECURITY</b>          |   |  |
| 13a. STATE<br><b>Maryland</b>   |   | 13b. COUNTY<br><b>Montgomery</b>  | 13c. CITY OR TOWN<br><b>Bethesda</b>                          | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>4740 Bradley Blvd, Apt. A-9</b>  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Peter Podelco</b>   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Mary OSTENOSKE</b>   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>yes</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>WW 2 219-14-5879</b>   | 17. INFORMANT ADDRESS<br><b>Lois M. Podelco (Same as 13e)</b> |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of tongue</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 months</b>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |   |   |   |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>June 24 1981</b> to <b>June 29 1981</b> that (I) (we) saw the deceased alive on <b>June 24 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                            |   |   |   |   |  |
| 22b. SIGNATURE<br><b>Peyton R. Evans, M.D.</b>  |   | DEGREE<br><b>M.D.</b>   |   | 22c. DATE SIGNED<br><b>6-30-81</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Peyton R. Evans, M.D.</b>   |   | 22e. ADDRESS<br><b>4900 Massachusetts Ave. N.W. Wash. D.C.</b>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  | 23b. DATE<br><b>7/2/81</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>PHILOS CEMETERY</b>  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>WESTERNPORT ALLEGANY MD.</b>                      |  |
| 24. FUNERAL DIRECTOR<br><b>BOAL'S FUNERAL SERVICE, P.A. WESTERNPORT, MD.</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 6 1981</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |

CONFIDENTIAL

RECEIVED JAN. 20, 1951

UNITED STATES DEPARTMENT OF JUSTICE

STATE DEPARTMENT (A-7)

SECRET

OFFICE OF THE ATTORNEY GENERAL

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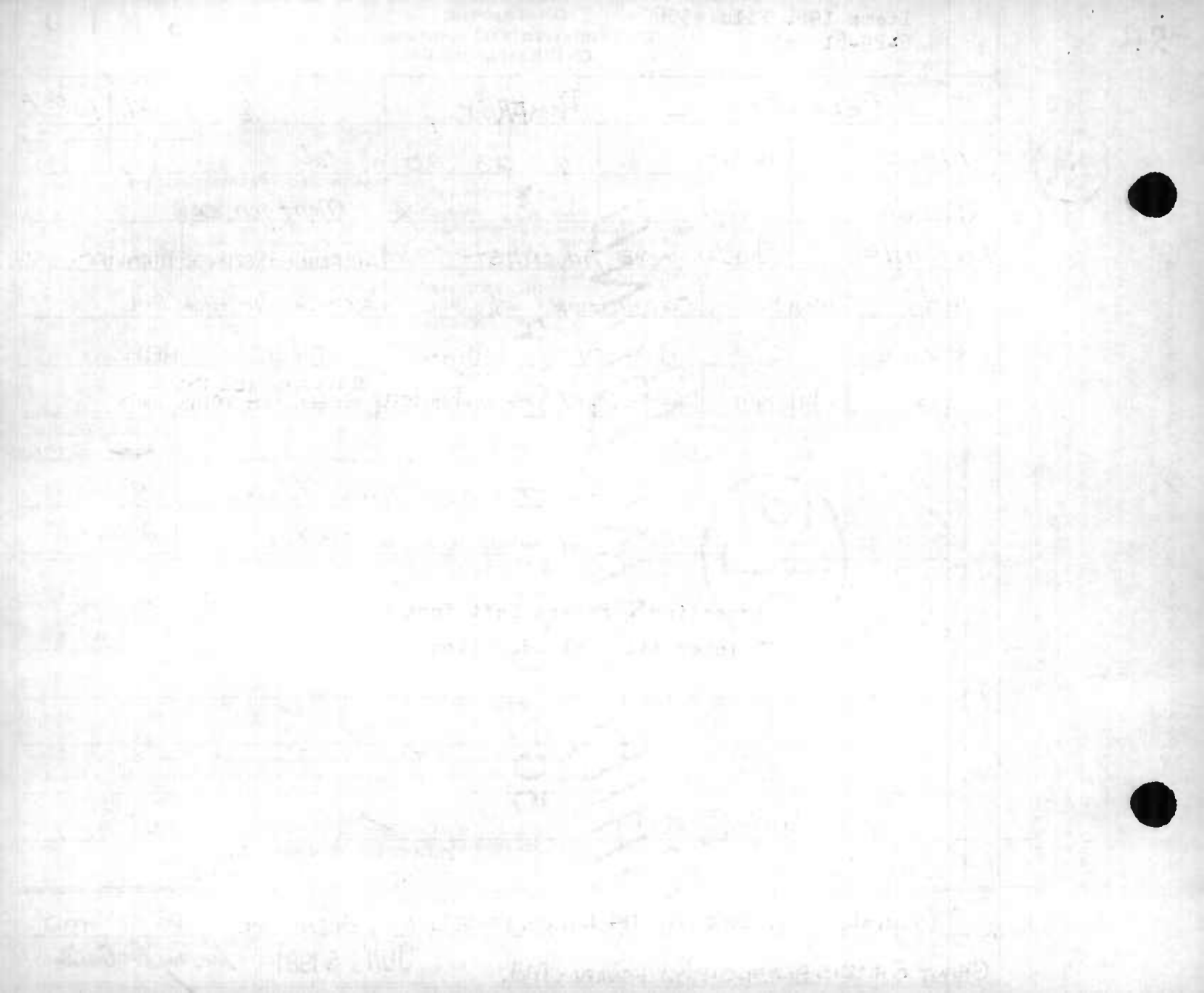
**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with          hour after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR<br>6-29-81 al   |  | Items 19b. Film #556<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  | 8 1 1 6 4 1 0  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>CELENOUS L. POMFREY  |  | 2a. DATE OF DEATH<br>MONTH 6 DAY 7 YEAR 81  |  | 2b. HOUR<br>10 55 A M  |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH 6 DAY 23 YEAR 80   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VIRGINIA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>60 YRS.   |  |
| 10. CITY OR TOWN OF DEATH<br>Rockville   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Shady Grove Adventist |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.   |  |
| 13a. STATE<br>md   |  | 13b. COUNTY<br>Mont.  |  | 13c. CITY OR TOWN<br>Germantown  |  |
| 14. FATHER'S NAME<br>FIRST GEORGE MIDDLE O LAST POMFREY  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MARIE MIDDLE REDFORD LAST   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SHIPPING+RECEIVER   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>YES   |  | 16b. SOCIAL SECURITY NO.<br>228-03-8287   |  | 17. INFORMANT<br>VERNON POMFREY  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>4479 IMMEDIATE CAUSE (a) Pulmonary embolus  |  | DUE TO, OR AS A CONSEQUENCE OF<br>(b) POST-OP AORTOFEMORAL BYPASS 5/28/81   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>20 MINS  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) POST-OP (2) LEG THROMBECTOMY 6/5/81  |  | 10 DAYS   |  | 2 DAYS   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>C.O.P.D.  |  |   |  |  |  |
| 19a. DATE OF OPERATION<br>6/5/81   |  | 19b. CONDITION OR WHICHERY OF DEATH<br>Impending gangrene left foot & Inferior vena caval disease & intermittent claudication   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/25, 19 81, to 6/1, 19 81, that (I) (we) lost saw the deceased alive on 6/1, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |
| 22b. SIGNATURE<br>Louis Korloff, M.D.  |  | DEGREE  |  | 22c. DATE SIGNED<br>6/7/81   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>LOUIS KORLOFF, M.D.   |  | 22e. ADDRESS<br>8218 WISCONSIN AVE. BETHESDA, MD. 20014   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>11 JUNE 1981   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Ft. LINCOLN CEMETERY...  |  |
| 24. FUNERAL DIRECTOR<br>NAME GRANT F.H. 9013 ANNAPOLIS Rd. Lanham Md.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BRENTWOOD PG MD.  |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 15 1981   |  |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| 1 - FOR<br>STATE<br>REGISTRAR  |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 8 1 1 6 4 1 1   |  |   |  |         |  |
|--|--|---|--|--|--|--|--|---|--|---|--|---------|--|
| CERTIFICATE OF DEATH   |  |   |  | REG. NO.   |  |  |  |   |  |   |  |         |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)   |  |   |  | FIRST MIDDLE LAST  |  |  |  | 2a DATE OF DEATH MONTH DAY YEAR                                 |  |   |  | 2b HOUR |  |
| WILLIAM AUGUSTUS PRATHER   |  |   |  |  |  |  |  | JUNE 6, 1981  |  |   |  | 7:30AM  |  |
| 3 SEX  |  | 4 RACE  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR  |  | 6 AGE (IN YEARS LAST BIRTHDAY)   |  | 7 UNDER 1 YEAR<br>MONTHS DAYS                                   |  | 7 UNDER 24 HRS<br>HOURS MIN                     |  |         |  |
| Male   |  | Black   |  | 10 12 98   |  | 82   |  |   |  |   |  |         |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH  |  |   |  |   |  |         |  |
| Maryland   |  | U.S.A.  |  |  |  | Montgomery MD.   |  |   |  |   |  |         |  |
| 10 CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b KIND OF BUSINESS OR INDUSTRY                |  |         |  |
| Olney  |  | Montgomery General Hospital   |  |  |  |  |  | Retired   |  | Laborer   |  |         |  |
| 13a STATE  |  | 13b COUNTY  |  | 13c CITY OR TOWN   |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                             |  | 13e STREET ADDRESS  |  |   |  |         |  |
| Maryland   |  | Montg.  |  | Gaithersburg   |  | XX   |  | 20014 Zion Road   |  |   |  |         |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST  |  |   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  |  |  |   |  |   |  |         |  |
| James Prather  |  |   |  | Willie Hall  |  |  |  |   |  |   |  |         |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)  |  | 17 INFORMANT ADDRESS   |  |  |  |   |  |   |  |         |  |
| No.  |  | 218-30-3484   |  | Mrs Sarah Prather (Wife) Same as 13#E  |  |  |  |   |  |   |  |         |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART 1. DEATH WAS CAUSED BY   |  |   |  |  |  |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |         |  |
| IMMEDIATE CAUSE (a) <u>cardiogenic shock</u>   |  |   |  |  |  |  |  |   |  |   |  |         |  |
| 4292 DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>congestive heart failure</u>   |  |   |  |  |  |  |  |   |  |   |  |         |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>atherosclerotic cardiovascular disease</u>   |  |   |  |  |  |  |  |   |  |   |  |         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.  |  |   |  |  |  |  |  |   |  |   |  |         |  |
| 19a DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |   |  |         |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |   |  |         |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                     |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |   |  |         |  |
|  |  |   |  |  |  |  |  |   |  |   |  |         |  |
| 22a I certify that (I) (this hospital) attended the deceased from <u>6/6</u> 19 <u>81</u> , to <u>6/6</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>6/6</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. |  |   |  |  |  |  |  |   |  |   |  |         |  |
| 22b SIGNATURE  |  |   |  | DEGREE   |  |  |  | 22c DATE SIGNED   |  |   |  |         |  |
| <u>Dr. Robert Millman</u>  |  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                            |  |  |  | <u>6/6/81</u>   |  |   |  |         |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  | 22e ADDRESS  |  |  |  |   |  |   |  |         |  |
| Dr. Robert Millman, M.D.   |  |   |  | 15 E. Deer Park Drive<br>Gaithersburg, MD 20760  |  |  |  |   |  |   |  |         |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE   |  | 23c NAME OF CEMETERY OR CREMATORY  |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE  |  |   |  |   |  |         |  |
| Burial   |  | 6-10-81   |  | Mt Zion Cemetery   |  | Mt Zion, Monyg. Md   |  |   |  |   |  |         |  |
| 24 FUNERAL DIRECTOR<br>NAME  |  |   |  | 24b ADDRESS  |  |  |  | 24c DATE REC'D BY REGISTRAR                                     |  |   |  |         |  |
| George R. Snowden  |  |   |  | Rockville, Md<br>246 N. Washington, St   |  |  |  | JUN 10 1981   |  |   |  |         |  |
|  |  |   |  | Rockville, Md  |  |  |  |   |  |   |  |         |  |

0100

718-30-3484 (MAY 20 1942)

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (1))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |  |  |   |  |                                 |  |                   |  |                                      |  |       |  |     |  |      |  |  |  |  |  |
|--|--|---|--|--|--|---|--|---------------------------------|--|-------------------|--|--------------------------------------|--|-------|--|-----|--|------|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST  |  | MIDDLE  |  | LAST                            |  | 2a. DATE OF DEATH |  | KNOWN ESTIMATED                      |  | MONTH |  | DAY |  | YEAR |  | 2b. HOUR                                     |  |  |  |
|  |  | Robert James Prentice   |  |  |  |   |  |                                 |  | 6                 |  | 7                                    |  | 19    |  | 81  |  |      |  | M  |  |  |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YR.                  |  | IF UNDER 24 HRS.  |  | 7c. DATE PRONOUNCED DEAD             |  | MONTH |  | DAY |  | YEAR |  | 2d. HOUR                                     |  |  |  |
| Male   |  | White   |  | Feb. 2, 1948   |  | 33 YRS.   |  |                                 |  |                   |  | 6                                    |  | 10    |  | 19  |  | 81   |  | 4:00 P M                                     |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED   |  | NEVER MARRIED   |  | WIDOWED                         |  | DIVORCED          |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |       |  |     |  |      |  |  |  |  |  |
| Rhode Island   |  | U.S.A.  |  |  |  |   |  |                                 |  |                   |  | Montgomery County, MD.               |  |       |  |     |  |      |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                    |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                                 |  |                   |  |                                      |  |       |  |     |  |      |  |  |  |  |  |
| None   |  | Cat Fish Hole - Potomac River   |  | Manager  |  | Finance   |  |                                 |  |                   |  |                                      |  |       |  |     |  |      |  |  |  |  |  |
| 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS             |  |                   |  |                                      |  |       |  |     |  |      |  |  |  |  |  |
| Maryland   |  | P.G. Co.  |  | Adelphi  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 1900 39th Street                |  |                   |  |                                      |  |       |  |     |  |      |  |  |  |  |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME  |  |  |  |   |  |                                 |  |                   |  |                                      |  |       |  |     |  |      |  |  |  |  |  |
| James C. Prentice  |  | Margaret Proulx   |  |  |  |   |  |                                 |  |                   |  |                                      |  |       |  |     |  |      |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT  |  | ADDRESS   |  |                                 |  |                   |  |                                      |  |       |  |     |  |      |  |  |  |  |  |
| Yes  |  | Vietnam   |  | 004-48-8143  |  | James C. Prentice   |  | Temaquid Trail Maine New Harbor |  |                   |  |                                      |  |       |  |     |  |      |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Drowning</u><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |  |  |   |  |                                 |  |                   |  |                                      |  |       |  |     |  |      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I   |  |   |  |  |  |   |  |                                 |  |                   |  |                                      |  |       |  |     |  |      |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |                                 |  |                   |  |                                      |  |       |  |     |  |      |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  | 21b. TIME OF INJURY   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)    |  |   |  |                                 |  |                   |  |                                      |  |       |  |     |  |      |  |  |  |  |  |
|  |  | 5 P.M. 6 7 81   |  | subject drowned while swimming   |  |   |  |                                 |  |                   |  |                                      |  |       |  |     |  |      |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION  |  |   |  |                                 |  |                   |  |                                      |  |       |  |     |  |      |  |  |  |  |  |
|  |  | river   |  | Cat Fish Hole - Potomac River, Mont. Co., MD.                                    |  |   |  |                                 |  |                   |  |                                      |  |       |  |     |  |      |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |  |  |   |  |                                 |  |                   |  |                                      |  |       |  |     |  |      |  |  |  |  |  |
| ACTUAL SIGNATURE   |  | TITLE (SPECIFY)   |  | DATE SIGNED  |  |   |  |                                 |  |                   |  |                                      |  |       |  |     |  |      |  |  |  |  |  |
| Virginia L. Dolan  |  | M.D. Assistant  |  | 6/11/81  |  |   |  |                                 |  |                   |  |                                      |  |       |  |     |  |      |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  | ADDRESS   |  |  |  |   |  |                                 |  |                   |  |                                      |  |       |  |     |  |      |  |  |  |  |  |
| Virginia L. Dolan, M.D.  |  | 111 Penn St. Balto., MD.  |  |  |  |   |  |                                 |  |                   |  |                                      |  |       |  |     |  |      |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  |                                 |  |                   |  |                                      |  |       |  |     |  |      |  |  |  |  |  |
| Cremation  |  | June/13/81  |  | Cedar Hill Crematory   |  | Suitland, P.G. Co., Maryland  |  |                                 |  |                   |  |                                      |  |       |  |     |  |      |  |  |  |  |  |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE RECD. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |                                 |  |                   |  |                                      |  |       |  |     |  |      |  |  |  |  |  |
| NAME   |  | ADDRESS   |  | JUN 19 1981  |  |   |  |                                 |  |                   |  |                                      |  |       |  |     |  |      |  |  |  |  |  |
| Chambers Funeral Home  |  | Riverdale, Maryland   |  |  |  |   |  |                                 |  |                   |  |                                      |  |       |  |     |  |      |  |  |  |  |  |

MEDICAL CERTIFICATION



1911

1911

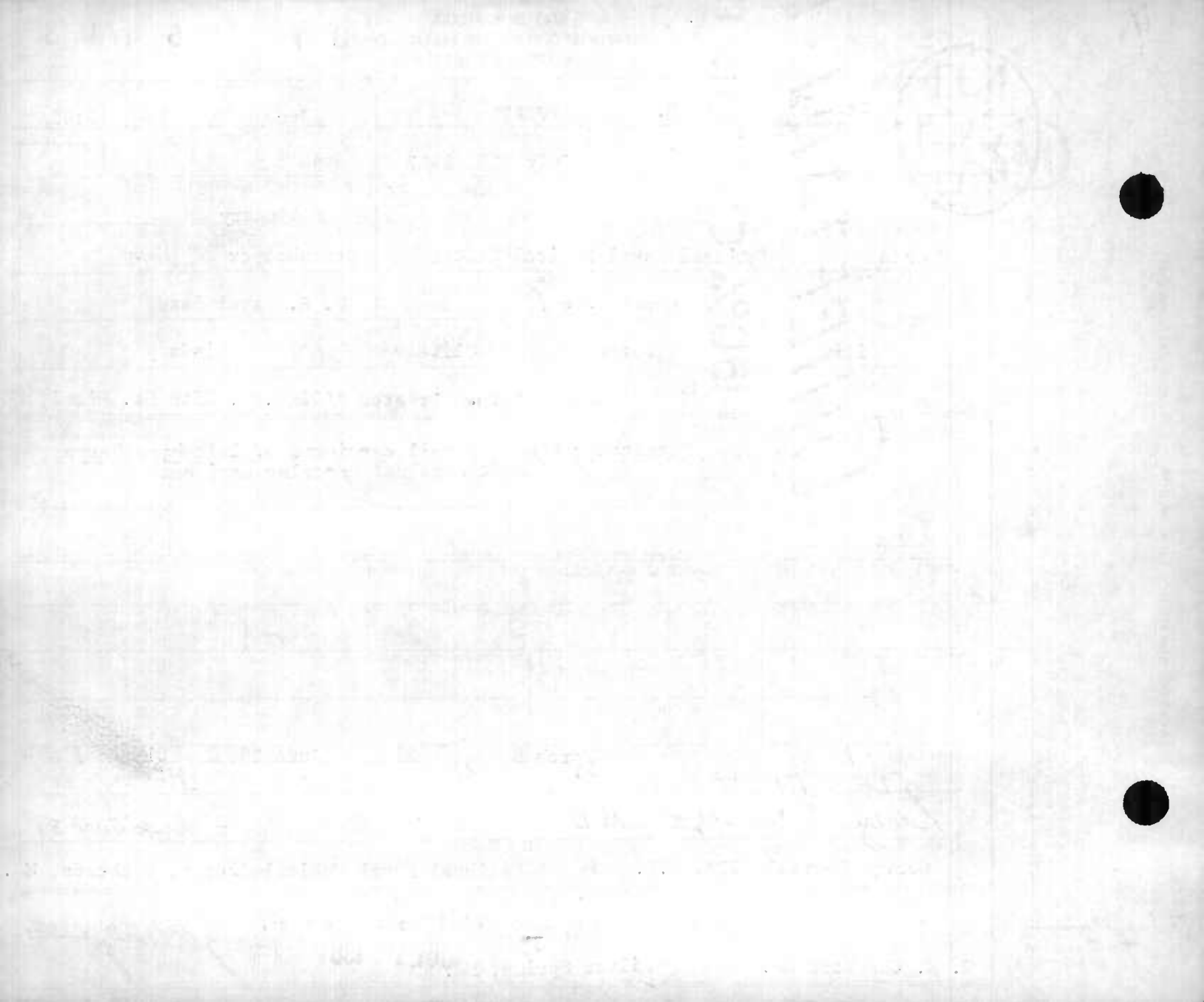
CHAPTER NINETEEN  
THE END OF THE WORLD  
THE END OF THE WORLD  
THE END OF THE WORLD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |   |  |   |                            |  |  |
|--|--|---|--|---|--|---|----------------------------|--|--|
| 1- FOR STATE REGISTRAR   |  |   |  |   |  |   |                            |  |  |
| CERTIFICATE OF DEATH   |  |   |  |   |  |   |                            |  |  |
| REG. NO.   |  |   |  |   |  |   |                            |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Frederick P. PRESTON</b>  |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>June 29 1981</b>   |   | 2b. HOUR<br><b>3:45A M</b> |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 28 1927</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>53</b> YRS.   |                            | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Cuba</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>Cuban</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                   |                            |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>National Naval Medical Center</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Storekeeper</b>          |                            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Navy</b>   |  |
| 13a. STATE<br><b>Cuba</b>  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Guantanamo</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                            | 13e. STREET ADDRESS<br><b>U. S. Naval Base</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Philip P Preston</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Olive Lindsey</b>  |   |                            |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>217 68 3800</b>  |  | 17. INFORMANT ADDRESS<br><b>Lathan Preston 1422 N. W. 35th St. Miami, FL</b>  |  |   |                            |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic squamous cell carcinoma of left hypopharynx;</b><br><b>1489</b> Left cerebral vascular accident<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |  |   |  |   |  |   |                            |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____  |  |   |  |   |  |   |                            |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |                            |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |                            |  |  |
| 22a. I certify that I (this hospital) attended the deceased from <b>March 9</b> 19 <b>81</b> , to <b>June 29</b> 19 <b>81</b> , that I (we) lost<br>saw the deceased alive on <b>June 29</b> 19 <b>81</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above. I (we) did not view the body after death.  |  |   |  |   |  |   |                            |  |  |
| 22b. SIGNATURE<br><b>George J. Farrell</b> M.D.  |  |   |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |                            | 22c. DATE SIGNED<br><b>30 June 81</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>George Farrell, III, M.D.</b>  |  |   |  |   | 22e. ADDRESS<br><b>National Naval Medical Center, Bethesda, Md.</b>  |   |                            |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Jul 1, 1981</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Maryland Nat, 1 Cem</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Laurel, Prince Geo, Md.</b>                    |                            |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>W. W. Chambers Co.</b>  |  |   |  |   | 25. DATE RECEIVED BY REGISTRAR<br>ADDRESS<br><b>Silver Spring, Md.</b>   |   |                            |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the health department.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|
| CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  |
| 1. FOR STATE REGISTRAR   |  |  |  |   | REG. NO.   |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Lena G. Privitera</b>   |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>6-28-81</b> 2b. HOUR <b>12 NOON</b>           |   |  |  |  |
| 3. SEX <b>F</b>  |  | 4. RACE <b>W</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>2 08 95</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |  |
| 8. BIRTHPLACE (COUNTRY) <b>DC</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>US.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD                                    |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>               |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>PG</b>   |  | 13c. CITY OR TOWN<br><b>Hyattsville</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1000 Ray Road</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Joseph Giardina</b>  |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Antoinette Conti</b>                |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>None</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>577 16 6502</b>   |  | 17. INFORMANT <b>12903 Kilgore Road, S.S. Md.</b><br><b>Johanna Maio (Daughter)</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Aortic Aneurysm</b><br><b>5601</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Chronic Megacolon</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Illeus</b>   |  |  |  |   |  |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>5/81</b><br><b>5/81</b><br><b>5/81</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>obesity, ASCVD, CHF, Acute &amp; Chronic UTI</b>   |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>None</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>None</b>  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br>OR CONTRIBUTING TO CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)<br><b>No</b>  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>12/11/80</b> , 19____, to <b>6/28/81</b> , 19____, that (I) (we) last saw the deceased alive on <b>6/28/81</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>HBPatrick III MD</b>  |  |  |  |   | DEGREE   |   |  | 22c. DATE SIGNED<br><b>6/28/81</b>           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Patrick, George III</b>  |  |  |  |   | 22e. ADDRESS<br><b>4221 Colesville Rd<br/>Silver Spring, Md 20910</b>                |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>   |  | 23b. DATE<br><b>7/1/81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Cemetery</b>   |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Brentwood PG Md.</b>  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Hines/Rinaldi F.H. 11800 N.H. Ave. S.S. Md.</b>   |  |  |  |   |  |   |  |  |  |

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 6 4 1 5

REG. NO.

|   |  |  |  |  |  |   |  |  |   |  |  |
|---|--|--|--|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | FIRST MIDDLE LAST<br>JOHN MUNSON RAMSEY  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>JUNE 26, 1981   |  |  | 2b. HOUR<br>8:33 p M  |  |  |
| 3. SEX<br>MALE  |  |  | 4. RACE<br>WHITE   |  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>NOV 2, 1910  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>70   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Missouri   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY COUNTY MD.   |  |  |
| 10. CITY OR TOWN OF DEATH<br>BETHESDA   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE CLINICAL CENTER NIH   |  |  |   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Ret.-Automotive Auto Factory                                      |  |  |
| 13a. STATE<br>MISSOURI  |  |  | 13b. CITY OR TOWN<br>St. Louis   |  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  | 13d. STREET ADDRESS<br>3250 N. WATERFORD (63033)  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Munson Ramsey   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Laurabelle Unknown  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |  |  | 16b. SOCIAL SECURITY NO.<br>488-03-3484   |  |  |
| 17. INFORMANT<br>ADDRESS<br>MRS. GOLDIE RAMSEY (NOK)  |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiac Arrest<br>0399<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) Disseminated Nocardia<br>(c) Disseminated Aspergillus |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Immediate<br>6 Months<br>6 months   |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from MAY 20, 1981 to JUNE 26, 1981, that (we) last saw the deceased alive on JUNE 26, 1981, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |  |   |  |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Marianne Frieri MD.  |  |  | 22c. NAME OF CEMETERY OR CREMATORY<br>Memorial Park Cem.   |  |  | 22d. ADDRESS<br>NATIONAL INSTITUTES OF HEALTH<br>CLINICAL CENTER, BETHESDA, MARYLAND 20205  |  |  | 22e. DATE SIGNED<br>6/27/81   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |  | 23b. DATE<br>6/30/81   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Memorial Park Cem.  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>St. Louis Missouri  |  |  |
| 24. FUNERAL DIRECTOR<br>Tyson Wheeler Funeral Home, Inc.<br>1331 Rockville Pike Rockville, Maryland   |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 1 1981   |  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



Minhenti

St. Louis

Madison

Will

Yes

James

Landreth

Unknown

Ref.-Automotive Auto Industry

10/24/81

6/30/81  
Tyrone Wheeler Funeral Home, Inc.  
1321 Rockville Pike, Rockville, Maryland  
Burial  
American Park Cem. Jennings St. Louis Missouri

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 6 4 1 6

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|   |   |  |   |   |   |
|---|---|--|---|---|---|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>Julio REATEGUI</b>   |   |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>June 10 1981</b>                                       |   | 2b HOUR<br><b>3:25A</b><br>M  |
| 3 SEX<br><b>Male</b>  | 4 RACE<br><b>Caucasian</b>  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov 2, 1928</b>  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>52</b>   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Peru</b>   | 7b CITIZEN OF WHAT COUNTRY?<br><b>Peru</b>  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b><br>MD.                                 |   |   |
| 10 CITY OR TOWN OF DEATH<br><b>Bethesda</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>National Naval Medical Center</b> |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Captain Peruvian Navy</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  | 13b. COUNTY<br><b>Montgomery</b>  | 13c. CITY OR TOWN<br><b>Bethesda</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>Apt. 302<br/>4520 East West Highway</b>                         |   |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Julio Reategui Gonzales</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Jobita Pezo</b>  |   |   |   |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |   | 16b SOCIAL SECURITY NO.<br><b>N/A</b>  |   | 17 INFORMANT<br><b>Rd. Bethesda, Md.<br/>CDR Enrique Villa Garcia, 4504 Jones Bridge/</b> |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hepatic failure, small bowel obstruction</b><br><b>5728</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>complicated by coagulopathy</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)<br>DUE TO, OR AS A CONSEQUENCE OF |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |   |  |   |   |   |
| 19a DATE OF OPERATION   |   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)              |   |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>May 29 1981</b> , to <b>June 10 1981</b> , that (I) (we) last saw the deceased alive on <b>June 10 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death.   |   |  |   |   |   |
| 22b SIGNATURE<br><b>Hal R Sessions III, M.D.</b>  |   |  |   | 22c. DATE SIGNED<br><b>June 11, 1981</b>  |   |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HAL R. SESSIONS III, M.D.</b>  |   |  |   | 22e ADDRESS<br><b>National Naval Medical Center, Bethesda, Md.</b>                        |   |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Removal</b>   |   | 23b DATE<br><b>June 11, 1981</b>   |   | 23c NAME OF CEMETERY OR CREMATORY<br><b>Peru</b>  |   |
| 23d LOCATION<br>CITY OR TOWN<br><b>Peru</b>   |   | 23e COUNTY<br><b>Peru</b>  |   | 23f STATE<br><b>Peru</b>  |   |
| 24 FUNERAL HOME<br>NAME ADDRESS<br><b>Hines-Rinaldi Funeral Home, 11800 New Hampshire/</b>  |   |  |   | 25 BY REGISTRAR<br><b>JUN 11 1981</b>   |   |
| 25 REGISTRAR'S SIGNATURE<br><b>Esty</b>   |   |  |   | 26 REGISTRAR'S SIGNATURE<br><b>Esty</b>   |   |

96  
27  
35  
150

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

6

1991, 11, 1991

1991, 11, 1991

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |   |   |  |   |  |  |  | 8  | 1 | 1   | 6  | 4 | 1 | 7                                  |  |  |
|---|--|--|---|---|--|---|--|--|--|--|---|---|--|---|---|------------------------------------|--|--|
| 1. FOR STATE REGISTRAR  |  |  |   |   |  |   |  |  |  | REG. NO.   |   |   |  |   |   |                                    |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>Margaret S. Reddersen</b>  |  |  |   |   |  |   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>June 14, 1981</b> 2b. HOUR<br><b>10:07PM</b>                  |   |   |  |   |   |                                    |  |  |
| 3. SEX<br><b>Female</b>   |  |  | 4. RACE<br><b>White</b>   |   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>11 4 1922</b>   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>58</b> YRS.  |  |   |   | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.<br><b>10:07PM</b>   |   |   |                                    |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Illinois</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                |  |   |   |  |   |   |                                    |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rockville</b>   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Shady Grove Adventist Hospital</b> |   |  |   |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>                    |   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |   |                                    |  |  |
| 13a. STATE<br><b>Maryland</b>   |  |  | 13b. COUNTY<br><b>Montgomery</b>  |   |  | 13c. CITY OR TOWN<br><b>Potomac</b>   |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   | 13e. STREET ADDRESS<br><b>9121 Paddock Lane</b>   |  |   |   |                                    |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Harold Hubert Sampson</b>   |  |  |   |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Ruth Allan</b>   |  |  |  |  |   |   |  |   |   |                                    |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>  |  |  |   |   |  | 16b. SOCIAL SECURITY NO.<br><b>253 30 4653</b>  |  |  | 17. INFORMANT ADDRESS<br><b>John Reddersen Same as item 13 a-e</b>                           |  |   |   |  |   |   |                                    |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ASPIRATION PNEUMONIA</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>LYMPHANGITIC CARCINOMA</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>BREAST CARCINOMA</b>   |  |  |   |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 DAY</b><br><b>6 weeks</b><br><b>1 1/2 years</b> |   |   |  |   |   |                                    |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>1749</b>  |  |  |   |   |  |   |  |  |  |  |   |   |  |   |   |                                    |  |  |
| MEDICAL CERTIFICATION   |  |  |   |   |  |   |  |  |  |  |   |   |  |   |   |                                    |  |  |
| 19a. DATE OF OPERATION  |  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                    |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |   |                                    |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |   |   |  |   |   |                                    |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |  |   |   |  |   |   |                                    |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>NOVEMBER 18 80</b> to <b>JUNE 14 81</b> , that (I) (we) lost saw the deceased alive on <b>JUNE 14 81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |   |  |   |  |  |  |  |   |   |  |   |   |                                    |  |  |
| 22b. SIGNATURE<br><b>Harold S. Mirsky</b>   |  |  |   |   |  |   |  |  |  | DEGREE<br><b>M.D.</b>  |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   | 22c. DATE SIGNED<br><b>6/15/81</b> |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Harold S. Mirsky</b>  |  |  |   |   |  |   |  |  |  | 22e. ADDRESS<br><b>730 24th St., N.W., Washington, D.C.</b>  |   |   |  |   |   |                                    |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |  |   | 23b. DATE<br><b>6/19/81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Memorial Park</b>  |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Skokie, Illinois</b>                                   |   |   |  |   |   |                                    |  |  |
| 24. FUNERAL DIRECTOR<br><b>Tyson Wheeler Funeral Home, Inc.</b>   |  |  |   |   |  |   |  |  |  | 25a. DATE REC'D BY REGISTRAR<br><b>JUN 18 1981</b>   |   |   |  |   |   |                                    |  |  |
| 1331 Rockville Pike Rockville, Md. 20852  |  |  |   |   |  |   |  |  |  |  |   |   |  |   |   |                                    |  |  |



|           |              |    |   |      |    |
|-----------|--------------|----|---|------|----|
| Female    | White        | 11 | 4 | 1952 | 88 |
| Illinois  | U.S.A.       |    |   |      |    |
| Rockville | Shady Grove  |    |   |      |    |
| Maryland  | Montgomery   |    |   |      |    |
| Harold    | Robert       |    |   |      |    |
|           | Bamson       |    |   |      |    |
|           | Busch        |    |   |      |    |
|           | 9121         |    |   |      |    |
|           | Parsons Lane |    |   |      |    |
|           | Housewife    |    |   |      |    |
|           | Montgomery   |    |   |      |    |
|           | White        |    |   |      |    |
|           | 11           |    |   |      |    |
|           | 4            |    |   |      |    |
|           | 1952         |    |   |      |    |
|           | 88           |    |   |      |    |

255 30 4055 John Redderson same as item 13 a-  
 - - -  
 6/10/81  
 Tyson Wheeler Funeral Home, Inc.  
 1771 Rockville Pike Rockville, Md. 20852  
 Rockville, Illinois  
 6/10/81  
 1771 Rockville Pike Rockville, Md. 20852

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 7/77

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  |   |  | REG. NO. 16418   |  |
|---|--|--|--|--|--|--|--|--|--|---|--|--|--|
| 1- STATE REGISTRAR  |  | 2a. DECEASED NAME (TYPE OR PRINT) <b>Mildred F. Reece</b>  |  |  |  |  |  | 2b. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <b>6 14 1981</b>                                   |  | 2c. DATE PRONOUNCED DEAD <b>June 14 1981</b>                              |  | 2d. HOUR <b>A</b>  |  |
| 3. SEX <b>Female</b>  |  | 4. RACE <b>Caucasian</b>   |  | 5. DATE OF BIRTH <b>February 20, 1921</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>54 RS.</b>  |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN   |  | IF UNDER 24 HRS. MONTHS DAYS HOURS MIN                                    |  | 2e. DATE PRONOUNCED DEAD <b>June 14 1981</b>                                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b>                                       |  |  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Bethesda</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>7709 Charlestown Dr</b> |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>                             |  |  |  |
| 13a. STATE <b>North Carolina</b>  |  | 13b. COUNTY <b>Guilford</b>  |  | 13c. CITY OR TOWN <b>Greensboro</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>1816 St. Andrews Rd.</b>  |  |   |  |  |  |
| 14. FATHER'S NAME FIRST <b>William</b> MIDDLE <b>F.</b> LAST <b>Hayworth</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Myra</b> MIDDLE <b>Gulley</b> LAST <b>Gulley</b>   |  |  |  |  |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>  |  | 16b. SOCIAL SECURITY NO. <b>240-38-9582</b>  |  | 17. INFORMANT ADDRESS <b>E. Kemp Reece Same as #13</b>   |  |  |  |  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>9552</b> IMMEDIATE CAUSE (a) <b>Gun Shot Wound of Head.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>Self Inflicted</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |  |  |  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |  |  |  |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |  |  |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>Pm 6-14 1981</b>   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Shot self. Rtt temple. 22 cal Rifle</b> |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Alone</b>   |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>7709 Charlestown Dr Bethesda Mont Md</b>                               |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |  |  |  |  |  |  |  |  |   |  |  |  |
| ACTUAL SIGNATURE <b>John G. Ball</b>  |  |  |  | TITLE (SPECIFY) <b>Deputy</b>  |  |  |  | DATE SIGNED <b>June 14, 1981</b>   |  |   |  | MEDICAL EXAMINER <b>7936 Old Georgetown Rd, Bethesda, Maryland</b>               |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>John G. Ball</b>   |  |  |  | ADDRESS <b>Bethesda, Maryland</b>  |  |  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  |  |  | 23b. DATE <b>June 16, 1981</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Forest Lawn Cemetery</b>                               |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Greensboro, North Carolina</b> |  |  |  |
| 24. FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey Funeral Home,</b>   |  |  |  | ADDRESS <b>Bethesda, Maryland</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>JUN 18 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>                             |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called by the hospital or attending physician.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |  |  |  |  |   |  | 8 1 1 6 4 1 9  |  |          |  |
|--|--|---|--|--|--|--|--|---|--|--|--|----------|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |   |  | CERTIFICATE OF DEATH   |  |  |  | REG. NO.  |  |  |  |          |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   |  | FIRST MIDDLE LAST  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR                                    |  |  |  | 7b. HOUR |  |
| HARVEY MONTGOMERY REED, SR.  |  |   |  |  |  |  |  | JUNE 1, 1981  |  |  |  | 7:26AM   |  |
| 3 SEX  |  | 4 RACE  |  | 5 DATE OF BIRTH  |  | 6 AGE (IN YEARS LAST BIRTHDAY)   |  | 7a. UNDER 1 YEAR  |  | 7b. UNDER 24 HRS   |  |          |  |
| MALE   |  | WHITE   |  | MONTH DAY YEAR<br>03 16 10   |  | 71 YRS   |  | MONTHS DAYS   |  | HOURS MIN.   |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH  |  |   |  |  |  |          |  |
| MARYLAND   |  | U.S.A.  |  |  |  | MONTGOMERY MD.   |  |   |  |  |  |          |  |
| 10 CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)    |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |          |  |
| OLNEY  |  | MONTGOMERY GENERAL HOSPITAL   |  |  |  |  |  | RETIRED   |  |  |  |          |  |
| 13a. STATE   |  |   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS  |  |          |  |
| MARYLAND   |  |   |  | MONTGOMERY   |  | GAIOTHERSBURG  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 18515 Strawberry Knoll   |  |          |  |
| 14 FATHER'S NAME   |  |   |  | 15 MOTHER'S MAIDEN NAME  |  |  |  |   |  |  |  |          |  |
| FIRST MIDDLE LAST  |  |   |  | FIRST MIDDLE LAST  |  |  |  |   |  |  |  |          |  |
| George W. Reed   |  |   |  | Liza Jane Gray   |  |  |  |   |  |  |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)  |  | 17 INFORMANT   |  |   |  |  |  |          |  |
| No   |  |   |  | -  |  | 215-18-0300  |  |   |  |  |  |          |  |
|  |  |   |  | Emily R. Reed  |  |  |  | 18515 Strawberry Knoll Gaithersburg, Md. 20760                      |  |  |  |          |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)<br>PART 1. DEATH WAS CAUSED BY:   |  |   |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |          |  |
| IMMEDIATE CAUSE (a) <u>Cardiogenic Shock Ventricular Fibrillation</u>  |  |   |  |  |  |  |  |   |  | 2 hours  |  |          |  |
| 4100 DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |  |  |  |  |   |  | 41 days  |  |          |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |   |  |  |  |  |  |   |  | ?  |  |          |  |
| (b) <u>Myocardial Infarction</u>   |  |   |  |  |  |  |  |   |  |  |  |          |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |  |  |  |  |   |  |  |  |          |  |
| (c) <u>AS H/D</u>  |  |   |  |  |  |  |  |   |  |  |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (e)  |  |   |  |  |  |  |  |   |  |  |  |          |  |
| <u>early vascular accident</u>   |  |   |  |  |  |  |  |   |  |  |  |          |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |          |  |
|  |  |   |  |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |  |  |          |  |
|  |  |   |  |  |  |  |  |   |  |  |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |  |  |          |  |
|  |  |   |  |  |  |  |  |   |  |  |  |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May 26</u> , 19 <u>81</u> , to <u>June 1</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>May 31</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |  |  |   |  |  |  |          |  |
| 22b. SIGNATURE   |  |   |  | DEGREE   |  |  |  | 22c. DATE SIGNED  |  |  |  |          |  |
| <u>Gregorio Kote</u>   |  |   |  |  |  |  |  | June 1 1981   |  |  |  |          |  |
| 22d. PHYSICIAN'S NAME  |  |   |  | 22e. ADDRESS   |  |  |  |   |  |  |  |          |  |
| GREGORIO KOTE MD   |  |   |  | 13 E. Penn Park Dr. Gaithersburg   |  |  |  |   |  |  |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |  |  |  |          |  |
| Burial   |  |   |  | June 3, '81  |  | Forest Oak Cemetery  |  | Gaithersburg Montg. Md.   |  |  |  |          |  |
| 24 FUNERAL DIRECTOR NAME   |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |          |  |
| Gartner Sandison F. H. 316 E. Diamond Ave. Gaithersburg, Md. 20760   |  |   |  |  |  | JUN 5 1981   |  | <u>Gregorio Kote</u>  |  |  |  |          |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 6 4 2 0

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ARTHUR T REMERS</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6 9 81</b> |   |  | 2b. HOUR<br>MIN<br><b>11 55 A</b>  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>CAUCASIAN</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 10 04</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><b>76</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>ENGLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD   |  |
| 10. CITY OR TOWN OF DEATH<br><b>ROCKVILLE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Collingswood Nursing Center</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Electrician</b>                                     |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Electrical</b>   |  | 13a. STREET ADDRESS<br><b>10 Whetstone Drive</b>  |  | 13b. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13c. STREET ADDRESS<br><b>10 Whetstone Drive</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES]<br><b>UNKNOWN</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>098-07-0261A</b>  |  |
| 17. INFORMANT<br><b>Records</b>  |  | ADDRESS<br><b>299 Hurley Ave.,</b>  |  | CITY OR TOWN<br><b>Rockville, Md.</b>   |  | STATE<br><b>Md.</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cerebrovascular accident</b><br>4392<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>(b) <b>arteriosclerotic cerebrovascular disease</b><br>(c) <b>heart</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 year</b> |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)<br><b>lung tumor</b>  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>6 May 81</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>lung tumor</b>   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>6 May 81</b> to <b>9 June 81</b> , that (I) <del>(we)</del> lost<br>saw the deceased alive on <b>1 June 81</b> , and that in my <del>(my)</del> opinion death occurred on the date and hour and from the causes stated<br>above, (I) <del>(we)</del> <del>(did not)</del> view the body after death.                                     |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Walter E. Goetz MD</b>  |  | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>9 June 81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>WALTER E. GOOZH MD</b>   |  | 22e. ADDRESS<br><b>2309 SHOREFIELD RD WHEATON MD</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   |  | 23b. DATE<br><b>6/10/81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lee's Crematory</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Washington, D.C.</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Gartner Sandison F. H.</b>  |  | ADDRESS<br><b>316 E. Diamond Ave., Gaithersburg, Md.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 12 1981</b>   |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |   |  |   |  |  |  |

1. The medical examiner must be notified at once.

2. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

3. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be not find at the

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |  |  |  |                 |     |       |           |     |
|--|--|---|--|---|--|---|--|--|--|-----------------|-----|-------|-----------|-----|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST   |  | MIDDLE  |  | LAST  |  | 2a. DATE OF DEATH  |  | MONTH           | DAY | YEAR  | 2b. HOUR  |     |
| HENRY  |  | THEODORE  |  | RENIERE   |  |   |  | JUNE 9 1981  |  |                 |     |       | 7:15 P.M. |     |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | 7. UNDER 1 YEAR  |  | 7. UNDER 24 HRS |     |       |           |     |
| MALE   |  | CAUCASIAN   |  | APRIL 20, 1916  |  | 65 YRS  |  | MONTHS   |  | DAYS            |     | HOURS |           | MIN |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |                 |     |       |           | MD. |
| MASSACHUSETTS  |  | U.S.A.  |  |   |  | MONTGOMERY  |  |  |  |                 |     |       |           |     |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |                 |     |       |           |     |
| WHEATON  |  | 12313 BLUHILL ROAD  |  | PROF. FAC. MGR.   |  | XEROX CORP.   |  |  |  |                 |     |       |           |     |
| 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS  |  |                 |     |       |           |     |
| MARYLAND   |  | MONTGOMERY  |  | WHEATON   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 12313 BLUHILL ROAD   |  |                 |     |       |           |     |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME  |  |   |  |   |  |  |  |                 |     |       |           |     |
| FIRST  |  | MIDDLE  |  | LAST  |  | FIRST   |  | MIDDLE   |  | LAST            |     |       |           |     |
| ALPHONSE   |  | RENIERE   |  |   |  | EVELYN  |  | BERNARD  |  |                 |     |       |           |     |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT   |  | ADDRESS   |  |  |  |                 |     |       |           |     |
| NO   |  | 101-03-4907   |  | YVETTE M. RENIERE   |  | SAME AS 13  |  | WIFE   |  |                 |     |       |           |     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a):                         |  | 1539  |  | CARCINOMA OF COLON  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                     |  | 5 YEARS  |  |                 |     |       |           |     |
| DUE TO, OR AS A CONSEQUENCE OF   |  | (b)   |  | DUE TO, OR AS A CONSEQUENCE OF  |  | (c)   |  |  |  |                 |     |       |           |     |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause last   |  |   |  |   |  |   |  |  |  |                 |     |       |           |     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                      |  |   |  |   |  |   |  |  |  |                 |     |       |           |     |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?   |  |  |  |                 |     |       |           |     |
|  |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |  |  |                 |     |       |           |     |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |                 |     |       |           |     |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |                 |     |       |           |     |
| 22a. I certify that (I) (this hospital) attended the deceased from   |  | FEBRUARY 1981   |  | to JUNE 9, 1981   |  | that (I) (we) last<br>saw the deceased alive on JUNE 8, 1981        |  | and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |                 |     |       |           |     |
| 22b. SIGNATURE   |  | DEGREE  |  | 22c. DATE SIGNED  |  |   |  |  |  |                 |     |       |           |     |
| Richard W. Holt MD   |  |   |  |   |  |   |  |  |  |                 |     |       |           |     |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS  |  |   |  |   |  |  |  |                 |     |       |           |     |
| RICHARD W. HOLT  |  | WHEATON   |  | MARYLAND  |  |   |  |  |  |                 |     |       |           |     |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |  |  |                 |     |       |           |     |
| BURIAL   |  | 6/11/81   |  | GATE OF HEAVEN  |  | SILVER SPRING MONT MD.  |  |  |  |                 |     |       |           |     |
| 24. FUNERAL DIRECTOR<br>NAME   |  | 24b. ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |                 |     |       |           |     |
| FRANCIS J. COLLINS   |  | 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901   |  | JUN 12 1981   |  | F. J. Collins   |  |  |  |                 |     |       |           |     |

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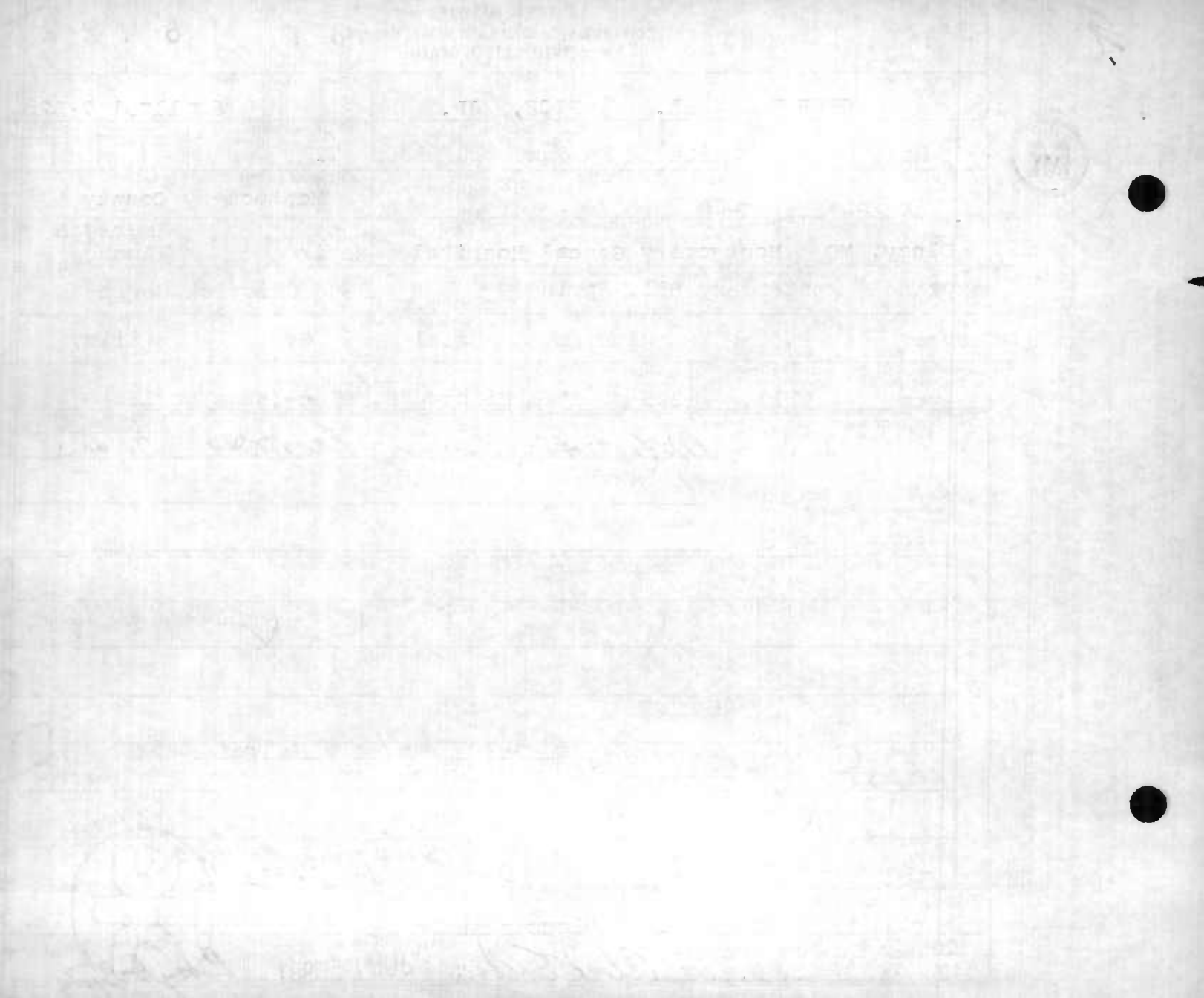
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| 1- FOR STATE REGISTRAR  |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 8 1 1 6 4 2 2   |  |  |  |
|---|--|---|--|--|--|---|--|---|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)  |  |   |  | 2a DATE OF DEATH   |  |   |  | 2b HOUR   |  |  |  |
| GEORGE A. RICE, JR.   |  |   |  | 6-11-81  |  |   |  | 7:52pm  |  |  |  |
| 3. SEX  |  | 4 RACE  |  | 5 DATE OF BIRTH  |  | 6 AGE (IN YEARS LAST BIRTHDAY)  |  | 7 IF UNDER 1 YEAR   |  | 7 IF UNDER 24 HRS  |  |
| Male  |  | White   |  | Jan. 15 1909   |  | 72  |  | MONTHS  |  | DAYS   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |  |  |
| Virginia  |  | USA   |  |  |  | Montgomery County MD.   |  |   |  |  |  |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b INDUSTRY  |  |   |  |  |  |
| Olney, MD   |  | Montgomery General Hospital   |  | Retired  |  | American Finance Systems  |  |   |  |  |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b STREET   |  |   |  | 13d INSIDE CITY LIMITS?  |  | 13e STREET ADDRESS  |  |   |  |  |  |
| Maryland Montgomery St. Spring  |  |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 3306 Chiswick Court   |  |   |  |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST   |  |   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  |   |  |   |  |  |  |
| George A. Rice, Sr.   |  |   |  | Hazel O. Riley   |  |   |  |   |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |  |   |  | 16b SOCIAL SECURITY NO.  |  | 17 INFORMANT (wife) ADDRESS   |  |   |  |  |  |
| yes WW1   |  |   |  | 225-07-1781  |  | Mildred B. Rice-(same as 13e)   |  |   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Metastatic Cancer Prostate</i><br>1850<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF                   |  |   |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 years  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |   |  |  |  |   |  |   |  |  |  |
| 19a DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |   |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |  |  |
| 22a. I certify that (1) this hospital attended the deceased from <i>8 June</i> 19 <i>81</i> to <i>11 June</i> 19 <i>81</i> that (1) (we) last saw the deceased alive on <i>6/10</i> 19 <i>81</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. If I was (did) unable to view the body after death. |  |   |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><i>[Signature]</i>  |  |   |  | DEGREE<br><i>MD</i>  |  |   |  | 22c. DATE SIGNED<br><i>6/11/81</i>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Lewis Kellert, MD</i>   |  |   |  | 22e. ADDRESS<br><i>1811 Prince Philip Dr<br/>Annapolis, Md. 20732</i>  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |  |  |
| Burial  |  |   |  | June 16 1981   |  | Gloucester Point  |  | Gloucester Point Va.  |  |  |  |
| 24. FUNERAL DIRECTOR<br>8434 Ga. Ave., S.S. Md.   |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |
| Walner E. Pumphrey, Inc.  |  |   |  |  |  | JUN 15 1981   |  | <i>[Signature]</i>  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-351-1500.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |   |   |  | 8 1 1 6 4 2 3  |  |
|---|---|---|--|--|--|
| 1. FOR STATE REGISTRAR  |   |   |  | REG. NO.   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Joan A. Richards</b>  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>June 29, 1981</b>                           |  | 2b. HOUR<br><b>6:50 P.M.</b>   |
| 3 SEX<br><b>Female</b>  | 4 RACE<br><b>White</b>  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>June 3, 1927</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>54</b> YRS.  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>England</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>British</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                |  |
| 10. CITY OR TOWN OF DEATH<br><b>Garrett Park</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>4507 Strathmore Ave.</b> |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Accountant</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Hotel</b>  |  |
| 13a. STATE<br><b>Md.</b>  |   |   | 13b. CITY OR TOWN<br><b>Garrett Park</b>   | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Joseph Enoch Cooper</b>   |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Louise Banfield</b>               |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>214-46-6621</b>  | 17. INFORMANT ADDRESS<br><b>Jane Murdock 2724 Hidden Rd. Vienna, Va.</b>           |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary Metastases</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Adenocarcinoma of Breast</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>1749</b> |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 yrs.</b><br><b>yrs.</b>   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>1749</b>  |   |   |  |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>         | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>6/1/81</b> to <b>6/29/81</b> , that (I) <del>did not</del> saw the deceased alive on <b>6/1/81</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> (did) <del>not</del> view the body after death.                            |   |   |  |  |  |
| 22b. SIGNATURE<br><b>G. Lennard Gold M.D.</b> DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |   |   |  | 22c. DATE SIGNED<br><b>6/29/81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>G. Lennard Gold, M.D.</b>   |   | 22e. ADDRESS<br><b>8630 Fenton St. Sil. Spg. Md.</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>   | 23b. DATE<br><b>6/30/81</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Crematory</b>   | 23d. LOCATION<br><b>Suitland, Md.</b> COUNTY STATE                                 |  |  |
| 24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b><br>NAME ADDRESS<br><b>5130 Wisc. Ave. N.W. Washington, D.C. 20016</b>  |   |   | 25a. DATE REGD. BY REGISTRAR<br><b>JUL 6 1981</b>                                  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

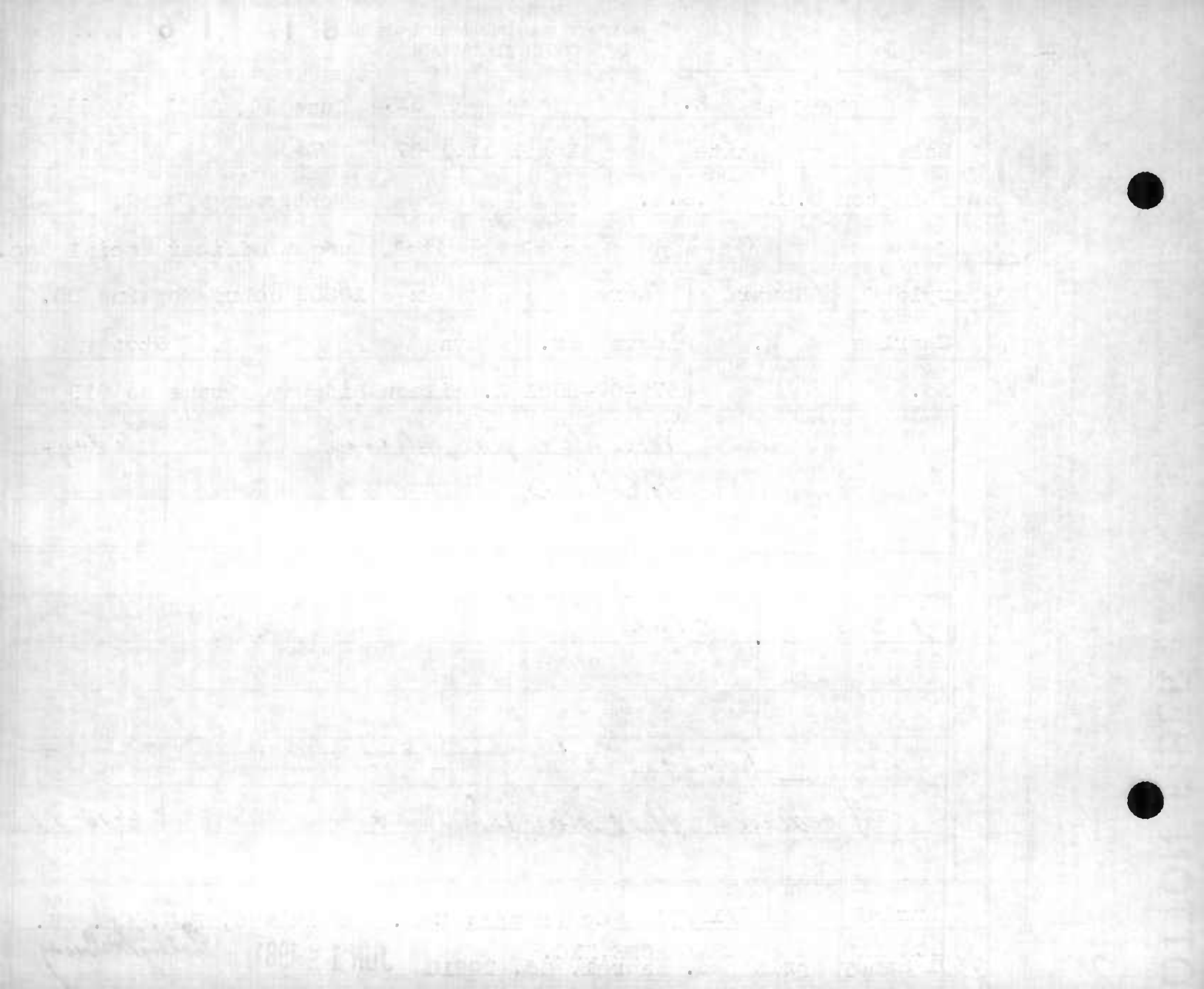
## CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |   |  |  |  |  |  |  |  |
|--|--|---|--|--|--|--|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>Charles E. Ridgway Jr.</b>  |  |   | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>June 10, 1981</b> |  |  | 2b HOUR<br><b>11:45pm</b>  |  |  |  |
| 3 SEX<br><b>Male</b>   |  | 4 RACE<br><b>White</b>  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April 11, 1907</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b>  |  | 7b HOUR<br>MONTHS DAYS HOURS MIN.<br><b>YRS</b>  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Washington D.C.</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County</b> MD.                      |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Olney</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Montgomery General Hospital</b> |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Budget Officer</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Social Sec.</b>  |  |
| 13a STATE<br><b>Maryland</b>   |  | 13b CITY OR TOWN<br><b>Howard</b>   |  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e STREET ADDRESS<br><b>10602 Johns Hopkins Rd.</b>                                     |  |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles E. Ridgway Sr.</b>   |  |   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Eva Storey</b>  |  |  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No.</b>  |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>579-09-6581</b>  |  | 17 INFORMANT<br>ADDRESS<br><b>E. Aileen Ridgway same as #13</b>  |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial infarction</b><br><b>4292</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ASCD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>8 days</b>  |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |   |  |  |  |  |  |  |  |
| 19a DATE OF OPERATION<br><b>6-3-81</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>same</b>   |  |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>May</b> , 19 <b>80</b> , to <b>June 10</b> , 19 <b>81</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>Jun. 9</b> , 19 <b>81</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> <del>(did)</del> <del>(do not)</del> view the body after death. |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Frederick Norman MD</b>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |  |  |  | 22c. DATE SIGNED<br><b>6-10-81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  | 22e. ADDRESS   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>6/15/81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cem.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Suitland, B.G. Co. Md.</b>              |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>FLECK LAUREL FUNERAL HOME, INC.</b><br><b>7601 Sandy Spring Rd. Laurel, Md. 20810</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 15 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Patricia M. Brady</b>                                   |  |  |  |





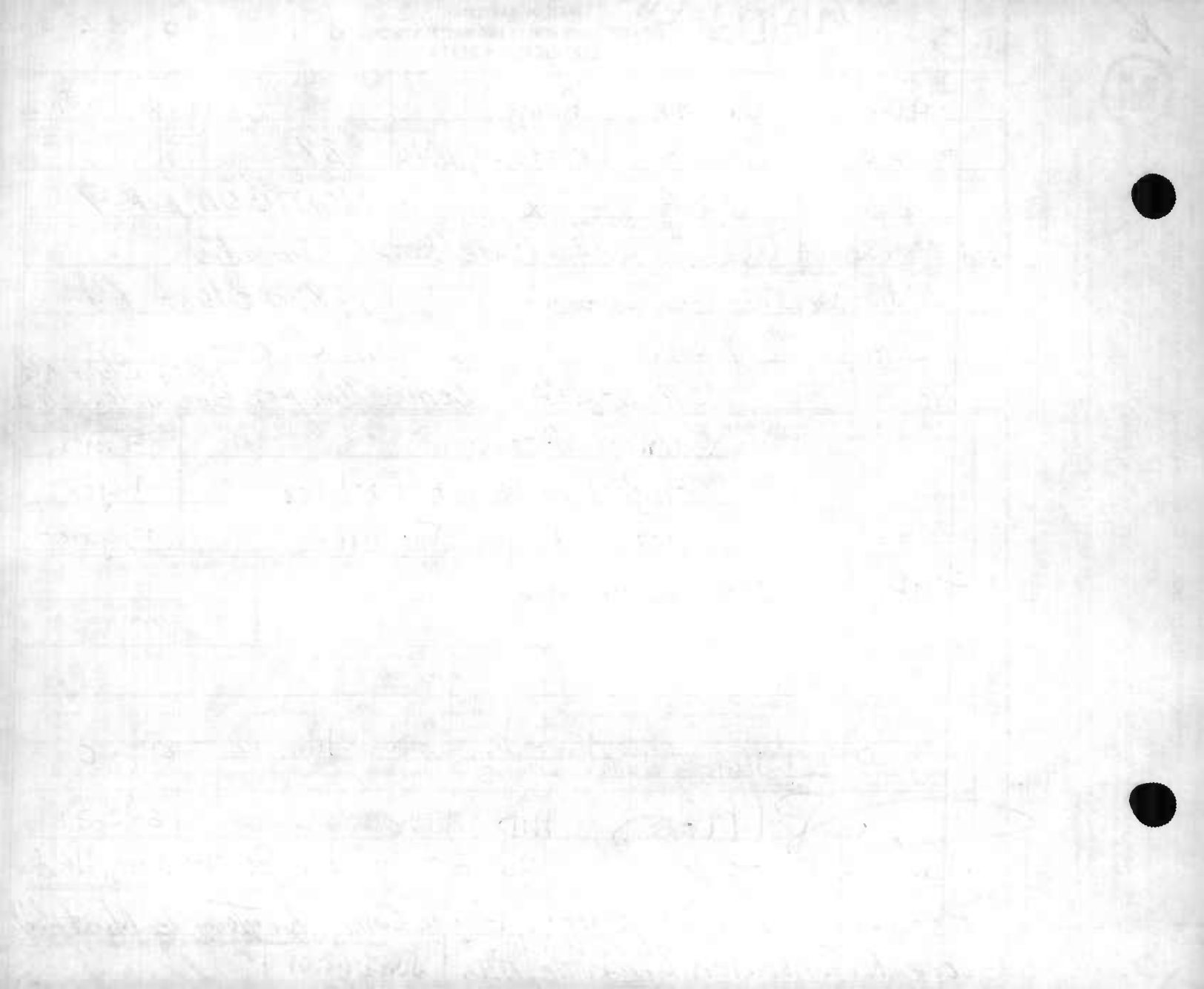


| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  | 8 1 1 6 4 2 5                                |  |                     |  |  |                    |  |  |
|---|--|--|--|--|--|--|--|--|--|--|--|---------------------|--|--|--------------------|--|--|
| 1. FOR STATE REGISTRAR  |  |  | REG. NO.   |  |  |  |  |  |  |  |  |                     |  |  |                    |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  | 2. DATE OF DEATH   |  |  | 3. MONTH   |  |  | 4. DAY   |  |  | 5. YEAR             |  |  | 6. HOUR            |  |  |
| ADA VIRGINIA Riggs  |  |  | 6-11-81  |  |  | 9:50   |  |  | AM   |  |  |                     |  |  |                    |  |  |
| 3. SEX  |  |  | 4. RACE  |  |  | 5. DATE OF BIRTH   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |  |  | 7. IF UNDER 1 YEAR  |  |  | 8. IF UNDER 24 HRS |  |  |
| Female  |  |  | BLACK  |  |  | Oct. 29, 1892  |  |  | 88   |  |  | MONTHS              |  |  | DAYS               |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |  |                     |  |  |                    |  |  |
| MD.   |  |  | U.S.A.   |  |  |  |  |  | MONTGOMERY   |  |  | MD.                 |  |  |                    |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |  |                     |  |  |                    |  |  |
| Gaithersburg  |  |  | WILSON Health Care Center  |  |  | Domestic   |  |  |  |  |  |                     |  |  |                    |  |  |
| 13a. STATE  |  |  | 13b. COUNTY  |  |  | 13c. CITY OR TOWN  |  |  | 13d. INSIDE CITY LIMITS?                                       |  |  | 13e. STREET ADDRESS |  |  |                    |  |  |
| Md.   |  |  | MONTG.   |  |  | Germantown   |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  | 19830 Blunt Rd.     |  |  |                    |  |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |  |  |  |                     |  |  |                    |  |  |
| David Williams  |  |  | Sarah Scott  |  |  |  |  |  |  |  |  |                     |  |  |                    |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  | 16b. SOCIAL SECURITY NO.   |  |  | 17. INFORMANT  |  |  | ADDRESS  |  |  |                     |  |  |                    |  |  |
| No  |  |  | 578-26-2353  |  |  | Bernice Williams   |  |  | 19824 Blunt Rd.  |  |  | Germantown Md.      |  |  |                    |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                     |  |  |                    |  |  |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Arrest  |  |  |  |  |  |  |  |  |  | 3 min  |  |                     |  |  |                    |  |  |
| 5850  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |                    |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure   |  |  |  |  |  |  |  |  |  | 1 year                                       |  |                     |  |  |                    |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Renal Failure  |  |  |  |  |  |  |  |  |  | 5 years                                      |  |                     |  |  |                    |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |                    |  |  |
| ASHD, Hypertension, Anemia  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |                    |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |                     |  |  |                    |  |  |
|   |  |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |                     |  |  |                    |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |  |  |                     |  |  |                    |  |  |
|   |  |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |  |  |  |  |  |                     |  |  |                    |  |  |
|   |  |  | P.M. 19  |  |  |  |  |  |  |  |  |                     |  |  |                    |  |  |
| 21d. INJURY OCCURRED  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |  | 21f. LOCATION  |  |  |  |  |  |                     |  |  |                    |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  |  |  | STREET   |  |  | CITY OR TOWN   |  |  |                     |  |  |                    |  |  |
|   |  |  |  |  |  | COUNTY   |  |  | STATE  |  |  |                     |  |  |                    |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from June 26, 1980, to June 12, 1981, that (I) (we) last saw the deceased alive on June 3, 1981, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |                    |  |  |
| 22b. SIGNATURE  |  |  | DEGREE   |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  |  | 22c. DATE SIGNED   |  |  |                     |  |  |                    |  |  |
| James R. Moore Jr.  |  |  | MD   |  |  |  |  |  | 6-12-81  |  |  |                     |  |  |                    |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  | 22e. ADDRESS   |  |  |  |  |  |  |  |  |                     |  |  |                    |  |  |
| James R. Moore Jr.  |  |  | 207 Brookes Ave Gaithersburg Md.   |  |  |  |  |  |  |  |  |                     |  |  |                    |  |  |
| 23a. BURIAL, CREMATION, REMOVAL   |  |  | 23b. DATE  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  | 23d. LOCATION  |  |  |                     |  |  |                    |  |  |
| Burial  |  |  | 6-16-81  |  |  | Brooke Grove Cam.  |  |  | Laytonsville, North Md.  |  |  |                     |  |  |                    |  |  |
| 24. FUNERAL DIRECTOR  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |  |                     |  |  |                    |  |  |
| George R. Snowden   |  |  | 246 N. Wash. St. Rockville, MD.  |  |  | JUN 17 1981  |  |  |  |  |  |                     |  |  |                    |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR<br>1- STATE REGISTRAR  |  |                  |  |  |  |                             |  |   |  |                            |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH |  |  |  |  |  |   |  |  |  |  |  | REG. NO. 16426          |  |
|--|--|------------------|--|--|--|-----------------------------|--|---|--|----------------------------|--|--|--|--|--|--|--|---|--|--|--|--|--|-------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>CLAIRE A. RIGHTSTINE</b>   |  |                  |  |  |  |                             |  |   |  |                            |  | 2a. DATE KNOWN OF DEATH ESTIMATED <b>June 10 1981</b>                              |  |  |  |  |  |   |  |  |  |  |  | 2b. HOUR <b>4:40 PM</b> |  |
| 3. SEX <b>F</b>  |  | 4. RACE <b>W</b> |  | 5. DATE OF BIRTH <b>Mar. 20 1935</b>   |  | 6. AGE (IN YEARS) <b>46</b> |  | IF UNDER 1 YR. MONTHS DAYS  |  | IF UNDER 24 HRS. HOURS MIN |  | 2c. DATE PRONOUNCED DEAD <b>June 10 1981</b>                                       |  |  |  |  |  |   |  |  |  |  |  | 2d. HOUR <b>4:40 PM</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>  |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |                             |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <b>XX</b> DIVORCED <input type="checkbox"/> |  |                            |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD</b>                          |  |  |  |  |  |   |  |  |  |  |  |                         |  |
| 10. CITY OR TOWN OF DEATH <b>Silver Spring</b>   |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Mary's Hosp</b> |  |                             |  |   |  |                            |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>ANALYST</b>       |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. GOVT.</b>  |  |   |  |  |  |  |  |                         |  |
| 13a. STATE <b>MD</b>   |  |                  |  |  |  |                             |  |   |  |                            |  | 13b. COUNTY <b>Montgomery</b>  |  | 13c. CITY OR TOWN <b>Silver Spring</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS <b>8711 Artists St.</b>                 |  |  |  |  |  |                         |  |
| 14. FATHER'S NAME <b>LYNN R.</b>   |  |                  |  | 15. MOTHER'S MAIDEN NAME <b>MARGARET REILLY</b>  |  |                             |  |   |  |                            |  |  |  |  |  |  |  |   |  |  |  |  |  |                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>   |  |                  |  | 16b. SOCIAL SECURITY NO. <b>230-24-2094</b>  |  |                             |  | 17. INFORMANT <b>SON</b>  |  |                            |  | ADDRESS <b>JOSEPH W. RIGHTSTINE, JR. SAME AS 13</b>                                |  |  |  |  |  |   |  |  |  |  |  |                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute myocardial Dis</b><br>4291 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>Chronic myocardial Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |                  |  |  |  |                             |  |   |  |                            |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Yrs.</b> |  |  |  |  |  |                         |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>None</b>  |  |                  |  |  |  |                             |  |   |  |                            |  |  |  |  |  |  |  |   |  |  |  |  |  |                         |  |
| 19a. DATE OF OPERATION <b>None</b>   |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |                             |  |   |  |                            |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |   |  |  |  |  |  |                         |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>   |  |                             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |                            |  |  |  |  |  |  |  |   |  |  |  |  |  |                         |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |                             |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |                            |  |  |  |  |  |  |  |   |  |  |  |  |  |                         |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                  |  |  |  |                             |  |   |  |                            |  |  |  |  |  |  |  |   |  |  |  |  |  |                         |  |
| ACTUAL SIGNATURE <b>John S. Rogers</b> M.D.  |  |                  |  |  |  |                             |  |   |  |                            |  | TITLE (SPECIFY) <b>Medical Examiner</b>  |  |  |  | DATE SIGNED <b>June 10 1981</b>  |  |   |  |  |  |  |  |                         |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>JOHN S. ROGERS</b>  |  |                  |  |  |  |                             |  |   |  |                            |  | ADDRESS <b>SILVER SPRING, MARYLAND</b>   |  |  |  |  |  |   |  |  |  |  |  |                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |  |                  |  | 23b. DATE <b>6/13/81</b>   |  |                             |  | 23c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN</b>  |  |                            |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>SILVER SPRING MONT MD.</b>              |  |  |  |  |  |   |  |  |  |  |  |                         |  |
| 24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b>  |  |                  |  |  |  |                             |  |   |  |                            |  | 25a. DATE REC'D. BY REGISTRAR <b>JUN 12 1981</b>                                   |  |  |  | 25b. <b>[Signature]</b>  |  |   |  |  |  |  |  |                         |  |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901  |  |                  |  |  |  |                             |  |   |  |                            |  |  |  |  |  |  |  |   |  |  |  |  |  |                         |  |

Check for \$100.00  
to the order of  
the Treasurer of the  
United States

for the sum of  
one hundred dollars

for the sum of  
one hundred dollars

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS ENCOUNTERED, PLEASE ADVISE THE MEDICAL EXAMINER. **TO JUDICIAL OFFICIAL:** EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN COLUMN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE JUDICIAL OFFICIAL. **TO FUNERAL DIRECTOR:** PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 1, 2, AND 3 TO THE JUDICIAL OFFICIAL. **TO FUNERAL DIRECTOR:** PAGE 5 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. BALTIMORE STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR ANATOMY.

DHMH-17  
(VR A15 ME (5))  
15M2/80

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |   |  | REG. NO.   |  |
|---|--|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Robert B. Rigot</b>   |  |  |  |  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>6-11-81</b> |  | 2b. HOUR<br>2:30 PM   |  |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 4 1965</b>  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS.<br><b>16</b>  |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN.   |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>June 14 1981</b>                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Penna.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery MD.</b>   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Great Falls</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Potomac River Great Falls</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Student</b>                           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>High School</b>                             |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  |  |  |  |  | 13b. COUNTY<br><b>Montgomery</b>  |  | 13c. CITY OR TOWN<br><b>Rockville</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William E. Rigot</b>   |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Christel Bastian</b>                                  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>361 62 9171</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>William E. Rigot Same as item 13 a-c</b>  |  |   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Drowning -</b><br>9109<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |  |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.   |  |  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  | 21b. TIME OF INJURY<br>HOUR MONTH DAY YEAR<br><b>2:30 P.M. 6-11-1981</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Fell in River - at Great Falls -</b>                                 |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>Potomac River</b>  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>Great Falls Montgomery Md.</b>   |  |   |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |  |  |  |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE<br><b>John G. Ball</b>   |  | TITLE (SPECIFY)<br><b>Deputy</b> M.D. MEDICAL EXAMINER   |  |  |  |   |  | DATE SIGNED<br><b>June 14, 1981</b>   |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>John G. Ball</b>  |  | ADDRESS<br><b>7936 Old Georgetown Rd Bethesda Md</b>   |  |  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>   |  | 23b. DATE<br><b>6-14-81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Metropolitan Crematory Alexandria</b>   |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Virginia</b>                       |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>1331 Rockville Pike Rockville, Md. 20852</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 17 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |   |  |   |  |  |  |



Wife  
 3 1955 12  
 7...A.

Student High School

William  
 301 02 9171  
 William H. Rigot Same as item 15-2-2  
 1901+ Wickshire way  
 X  
 Rockville  
 Montgomery  
 Maryland

1931 Rockville Pike Rockville, Md. 20852  
 Tyson Wheeler Funeral Home, Inc.  
 6-11-81 Metropolitan Crematory Alexandria  
 Virginia  
 John G. Hall  
 7936 Old Georgetown Rd Bethesda Md.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |   |   |  |   |  |   |   |  |  |  |  |
|--|--|---|--|---|---|--|---|--|---|---|--|--|--|--|
| 1- FOR STATE REGISTRAR   |  |   |  |   | 8 1 1 6 4 2 8   |  |   |  |   |   |  |  |  |  |
| CERTIFICATE OF DEATH   |  |   |  |   | REG. NO.  |  |   |  |   |   |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>GRIFFEN W. Ritnour</b>   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>June 4, 1981</b>                |  |   |  |   | 2b. HOUR<br><b>8:45 P M</b>   |  |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 12, 1902</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>78</b>  |   | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>78</b>   |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County MD.</b>   |   |  |   |   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rockville</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Collingswood Nursing Center</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Sales Rep.</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Plumbing &amp; Heating Co</b>                |   |   |  |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  |   |  |   | 13b. COUNTY<br><b>Montgomery</b>  |  | 13c. CITY OR TOWN<br><b>Rockville</b>                             |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  | 13e. STREET ADDRESS<br><b>316 Lorraine Drive</b> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Hunter Ritnour</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Florence Anderson</b> |  |   |  |   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  |   |  |   | 16b. SOCIAL SECURITY NO.<br><b>577-07-9335</b>                            |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Helen Ritnour same as #13</b> |  |   |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>1629 IMMEDIATE CAUSE (a) Bronchogenic Carcinoma</b>   |  |   |  |   |   |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>14mo</b>  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____  |  |   |  |   |   |  |   |  |   |   |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |   |  |   |   |  |   |  |   |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)   |  |   |  |   |   |  |   |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |   |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |   |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6/21/81</b> to <b>6/4/81</b> , that (I) (we) lost<br>saw the deceased alive on <b>6/21/81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I/we) (we) did not view the body after death. |  |   |  |   |   |  |   |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br><b>Robert C. Macon M.D.</b>  |  |   |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>6/5/81</b>  |   |   |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robert C. Macon M. D.</b>  |  |   |  |   |   | 22e. ADDRESS<br><b>809 Viers Mill Rd. Rockville MD 20851</b>   |   |  |   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   |  | 23b. DATE<br><b>June 8, 1981</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parklawn Memorial Park</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Rockville, Maryland</b>             |   |   |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Robert A. Pumphrey Funeral Homes P.A., Bethesda, Maryland</b>   |  |   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 11 1981</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Patricia K. Brady</i>                               |   |   |  |  |  |  |

MEDICAL CERTIFICATION

29

0905-BP

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Received  
of  
under

SECTION

TO THE  
FROM THE  
DATE  
1971-05-19  
1971-05-19

RECEIVED  
DATE  
1971-05-19  
1971-05-19

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSPORT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| FOR STATE REGISTRAR  |  |         |  |   |  |                         |  |  |  | REG. NO.         |  |  |  |        |  |
|--|--|---------|--|---|--|-------------------------|--|--|--|------------------|--|--|--|--------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |         |  |   |  | 2a. DATE KNOWN OF DEATH |  | MONTH  |  | DAY              |  | YEAR   |  | HOUR   |  |
| MAYNARD  |  |         |  |   |  | ROBINSON, SR.           |  | June 25  |  | 19               |  | 1981   |  | 11a.m. |  |
| 3. SEX   |  | 4. RACE |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)       |  | IF UNDER 1 YR.   |  | IF UNDER 24 HRS. |  | 7c. DATE PRONOUNCED DEAD                                 |  | HOUR   |  |
| MALE   |  | WHITE   |  | JAN 28, 1919  |  | 62 YRS.                 |  | MONTHS   |  | DAYS             |  | HOURS  |  | MIN    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |         |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |                         |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                     |  |        |  |
| WASHINGTON, DC   |  |         |  | U.S.A.  |  |                         |  |  |  |                  |  | MONTGOMERY   |  |        |  |
| 10. CITY OR TOWN OF DEATH  |  |         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                         |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |                  |  | 12b. KIND OF BUSINESS OR INDUSTRY                        |  |        |  |
| Silver Spring  |  |         |  | Holy Cross Hospital   |  |                         |  | ACCT. EX.  |  |                  |  | W.L.MD. RADIO  |  |        |  |
| 13a. STATE   |  |         |  | 13b. COUNTY   |  |                         |  | 13c. CITY OR TOWN  |  |                  |  | 13d. INSIDE CITY LIMITS?                                 |  |        |  |
| Maryland   |  |         |  | MONTGOMERY  |  |                         |  | Silver Spring  |  |                  |  | YES <input type="checkbox"/> NO <input type="checkbox"/> |  |        |  |
| 14. FATHER'S NAME  |  |         |  | 15. MOTHER'S MAIDEN NAME  |  |                         |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |  |                  |  | 16b. SOCIAL SECURITY NO.                                 |  |        |  |
| OSCAR  |  |         |  | KATHERINE   |  |                         |  | YES  |  |                  |  | WW II  |  |        |  |
| 17. INFORMANT  |  |         |  | ADDRESS   |  |                         |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |                  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH             |  |        |  |
| GERTRUDE L. ROBINSON   |  |         |  | SAME AS 13 WIFE   |  |                         |  | PART 1 DEATH WAS CAUSED BY:  |  |                  |  |  |  |        |  |
| IMMEDIATE CAUSE (a)  |  |         |  | DUE TO, OR AS A CONSEQUENCE OF  |  |                         |  | 4291   |  |                  |  |  |  |        |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |  |         |  | (b)   |  |                         |  | Chronic Myocardial Dis.  |  |                  |  | XV   |  |        |  |
| (c)  |  |         |  |   |  |                         |  |  |  |                  |  |  |  |        |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |         |  |   |  |                         |  |  |  |                  |  |  |  |        |  |
| None   |  |         |  |   |  |                         |  |  |  |                  |  |  |  |        |  |
| 19a. DATE OF OPERATION   |  |         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |                         |  | 20. AUTOPSY?   |  |                  |  |  |  |        |  |
| None   |  |         |  |   |  |                         |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |                  |  |  |  |        |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |         |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  |  |                         |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |                  |  |  |  |        |  |
|  |  |         |  | P.M. 19   |  |                         |  |  |  |                  |  |  |  |        |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |                         |  | 21f. LOCATION  |  |                  |  |  |  |        |  |
|  |  |         |  |   |  |                         |  | STREET   |  |                  |  | CITY OR TOWN COUNTY STATE                                |  |        |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |         |  |   |  |                         |  |  |  |                  |  |  |  |        |  |
| ACTUAL SIGNATURE   |  |         |  | TITLE (SPECIFY)   |  |                         |  | DATE   |  |                  |  |  |  |        |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  |         |  | ADDRESS   |  |                         |  | MEDICAL EXAMINER   |  |                  |  | SIGNED   |  |        |  |
| JOHN S. ROGERS   |  |         |  | 1919 SEMINARY ROAD, SILVER SPRING, MD.  |  |                         |  | Def  |  |                  |  | June 25, 1981  |  |        |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |         |  | 23b. DATE   |  |                         |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |                  |  | 23d. LOCATION  |  |        |  |
| BURIAL   |  |         |  | 6/29/81   |  |                         |  | GATE OF HEAVEN   |  |                  |  | SILVER SPRING MONT MD.                                   |  |        |  |
| 24. FUNERAL DIRECTOR NAME  |  |         |  | 25a. DATE REC'D. BY REGISTRAR   |  |                         |  | 25b. REGISTRAR'S SIGNATURE   |  |                  |  |  |  |        |  |
| FRANCIS J. COLLINS   |  |         |  | JUN 30 1981   |  |                         |  | Rufus Hebrady  |  |                  |  |  |  |        |  |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901  |  |         |  |   |  |                         |  |  |  |                  |  |  |  |        |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be retained by the funeral director, page 3 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |   |  |   |   |  |
|---|--|---|--|---|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Lois ALICE Rockelli</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR <b>06-14-81</b>               |   |   | 2b. HOUR MIN <b>10:45 P M</b>  |   |   |  |
| 3. SEX <b>FEMALE</b>  |  | 4. RACE <b>WHITE</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>12-24-13</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS.   |   | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (COUNTRY) <b>USA (Va.)</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery Co. MD.</b>   |   |   |  |
| 10. CITY OR TOWN OF DEATH <b>Silver Spring</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b> |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>XXXXXXXXXX</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY <b>MANAGER C &amp; P</b>  |  |
| 13a. STATE <b>MD.</b>   |  | 13b. CITY OR TOWN <b>P.C. LEWISDALE</b>   |  | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 13d. STREET ADDRESS <b>2200 Banning Pl.</b>  |   |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN COBB</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARTHA HOIT</b>   |   |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO XXXXXXXX</b>  |  |   |  | 16b. SOCIAL SECURITY NO. <b>577-01-2583</b>   |   | 17. INFORMANT <b>DAUGHTER SHERRON A. ROCKELLI</b>  |   | ADDRESS <b>9802 GEORGIA AVE. SILVER SPRING, MD.</b>   |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cerebro Vascular Accident</b><br><b>4360</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |   |  |   |   |  |   |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED               |   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>    |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1; OR PART 2) |  |   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.) |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                  |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>June 5</b> , 19 <b>1981</b> , to <b>June 14</b> , 19 <b>81</b> , that (I) (we) saw the deceased alive on <b>June 14</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.       |  |   |  |   |   |  |   |   |  |
| 22b. SIGNATURE <b>Bernard A. Fitzgerald</b>   |  |   | DEGREE   |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED <b>6/14/81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BERNARD A. FITZGERALD</b>  |  |   | 22e. ADDRESS <b>217 University Blvd E, Silver Spring, MD</b>   |   |   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>   |  |   | 23b. DATE <b>6/18/81</b>                                       |   | 23c. NAME OF CEMETERY OR CREMATORY <b>BLANDFORD CEMETERY</b>                    |  | 23d. LOCATION CITY <b>PETERSBURG</b> COUNTY <b>VIRGINIA</b> |   |  |
| 24. FUNERAL DIRECTOR (NAME) <b>FRANCIS J. COLLINS</b>   |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR <b>JUN 15 1981</b>                                |  | 25b. REGISTRAR'S SIGNATURE <b>Richard McCreedy</b>          |   |  |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901   |  |   |  |   |   |  |   |   |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  | REG. NO. 16431   |  |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |  |  |  |  |  |  | 7a. DATE KNOWN OF DEATH                                    |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Winnona M. Rollins</b>   |  |  |  |  |  |  |  |  |  | MONTH DAY YEAR   |  |
| 2. SEX <b>F</b> RACE <b>W</b> DATE OF BIRTH <b>August 18, 1908</b> AGE (IN YEARS) <b>81</b> YRS. IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.  |  |  |  |  |  |  |  |  |  | 2b. DATE PRONOUNCED DEAD <b>June 11, 1981</b>              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b> 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b> 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b> |  |
| 10. CITY OR TOWN OF DEATH <b>Olney</b> 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sharon N. Home</b> 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b> 12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>   |  |  |  |  |  |  |  |  |  |  |  |
| 13a. STATE <b>MD</b> 13b. CITY OR TOWN <b>Prince George</b> 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13d. STREET ADDRESS <b>906 White Oak Dr.</b>  |  |  |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) <b>ARTHUR EDWIN FREAKLEY</b> 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) <b>UNK. MACEY</b>  |  |  |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b> (IF YES, GIVE WAR OR DATES) <b>NONE</b> 16b. SOCIAL SECURITY NO. <b>070-07-48420</b> 17. INFORMANT <b>C. RAY ROLLINS</b> ADDRESS <b>SAME AS ITEM 13</b>   |  |  |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>1534</b> IMMEDIATE CAUSE (a) <b>Carcinoma of Cecum</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH               |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Fracture Rt. Hip</b>   |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION <b>1-21-81</b> 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>Fracture Rt. Hip</b> 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH <b>P.M. Jan 18, 1981</b> 21b. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Fell in room</b>  |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Nursing Home</b> 21f. LOCATION (STREET CITY OR TOWN COUNTY STATE) <b>Olney Mont and</b>   |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>John P. Rogers</b> M.D. TITLE (SPECIFY) <b>Dep</b> MEDICAL EXAMINER DATE SIGNED <b>June 11, 1981</b>   |  |  |  |  |  |  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) ADDRESS  |  |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b> 23b. DATE <b>June 15, 1981</b> 23c. NAME OF CEMETERY OR CREMATORY <b>First Lutheran Cemetery</b> 23d. LOCATION (CITY OR TOWN COUNTY STATE) <b>Buffalo Erie N.Y.</b>  |  |  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME <b>G.P. KALAS</b> ADDRESS <b>6160 Oxon Hill Rd. Oxon Hill, MD</b> 25a. DATE REC'D. BY REGISTRAR <b>JUN 16 1981</b> REGISTRAR'S SIGNATURE <b>John P. Rogers</b>   |  |  |  |  |  |  |  |  |  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |   |   |   |  |   |   |
|--|--|--|---|---|---|---|--|---|---|
| 1. FOR<br>STATE<br>REGISTRAR   |  |  | REG. NO.  |   |   |   |  |   |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Robert S. Rozman</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6/18/81</b>                   |   |   |   | 2b. HOUR<br><b>7:10 A.M.</b>                     |   |   |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 28 31</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>49</b>  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS.</b>  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Washington, DC</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County</b> MD.  |  |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Kensington</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3514 Astoria Court</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Pharmacologist</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Govt.</b>  |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  |  | 13b. CITY OR TOWN<br><b>Montgomery</b>                                  |   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13d. STREET ADDRESS<br><b>3514 Astoria Court</b> |   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Armin Rozman</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Julia Schonwald</b> |   |   |   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>---</b>  |   | 17. INFORMANT (wife) ADDRESS<br><b>Phyllis M. Rozman-(same as 13e)</b>  |   |   |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Gastrointestinal hemorrhage</b><br><b>1550</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Hepatocellular carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Hemophilia A</b><br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |   |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 Day</b><br><b>5 Months</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d)  |  |  |   |   |   |   |  |   |   |
| 19a. DATE OF OPERATION<br><b>5/22/81</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Hepatic tumor</b>   |   |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)  |   |   |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>DECEMBER 5 1966</b> , to <b>JUNE 18 1981</b> , that (I) (we) lost saw the deceased alive on <b>JUNE 17 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.  |  |  |   |   |   |   |  |   |   |
| 22b. SIGNATURE<br><b>Richard M. Kaufman</b>  |  |  |   |   |   | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>JUNE 18, 1981</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Richard M. Kaufman, M.D., F.A.C.P.</b>   |  |  |   |   |   | 22e. ADDRESS<br><b>1145 19th Street, N.W. Washington, D.C.</b>  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>6-21-1981</b>  |   | 23c. NAME OF CEMETERY<br><b>Memorial</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Falls Church Va.</b>   |  |   |   |
| 24. FUNERAL DIRECTOR<br><b>Warner E. Pumphrey, Inc.</b><br><b>8434 Ga. Ave., S.S. Md.</b>  |  |  |   |   |   | 25. DATE REC'D. BY REGISTRAR<br><b>JUN 23 1981</b>  |  |   |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 8 1 1 6 4 3 3   |  |  |  |
|--|--|---|--|---|--|--|--|
| FOR<br>1 - STATE REGISTRAR   |  |   |  | REG. NO.  |  |  |  |
| 1 DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ROBERT C. RUBEN</b>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>June 22, 1981</b>  |  | 2b. HOUR<br><b>10<sup>45</sup> PM</b>  |  |
| 3 SEX<br><b>Male</b>   |  | 4 RACE<br><b>Caucasian</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Feb. 16, 1923</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>58</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Minnesota</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery Co., MD.</b>  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Chevy Chase</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>4137 Woodbine St.</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Adm. Ass't.</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Congress.</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |  |   |  | 13b. COUNTY<br><b>Montgomery</b>  |  | 13c. CITY OR TOWN<br><b>Chevy Chase</b>  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>Albert G. Ruben</b>   |  |   |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Ruth Bachman</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br><b>WW II</b>  |  | 17 INFORMANT ADDRESS<br><b>Margit M. Ruben/Wife/Same as 13</b>  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Ventilatory Failure</b><br>3352 } DUE TO, OR AS A CONSEQUENCE OF:<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Amyotrophic Lateral Sclerosis</b><br>18 months<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>48 hours</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>NONE</b>   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>NONE</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>March</b> 19 <b>80</b> , to <b>June 22</b> 19 <b>81</b> , that (I) (we) lost<br>saw the deceased alive on <b>June 20</b> 19 <b>81</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.                            |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Stanley Cohan, MD</b>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>June 22, 1981</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>STANLEY COHAN</b>  |  |   |  | 22e. ADDRESS<br><b>3800 Reservoir Rd, NW, Wash, D.C. 20007</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>June 23, 1981</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lee's Crematory</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Washington, D.C.</b>   |  |
| 24 FUNERAL DIRECTOR NAME ADDRESS<br><b>Capitol Funeral Service, Fairfax, Va.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 25 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert M. ...</b>   |  |

Capital Federal Savings Bank, Va.

Operation June 23, 1951 Lee's Grocery Washington, D.C.

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**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |                         |   |  |  |  |   |   |
|---|-------------------------|---|--|--|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>John M. St. Peter, Sr.</b>   |                         |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <b>June 29, 1981</b>  |  | 2b. HOUR<br><b>A</b>  |   |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>Cauc.</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 7, 1910</b>   | 6. AGE [IN YEARS]<br>(LAST BIRTHDAY)<br><b>70 YRS.</b> | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.   | 7c. DATE PRONOUNCED DEAD<br><b>June 29, 1981</b>   | 2d. HOUR<br><b>11:30 A</b>  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Michigan</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b>                                       |   |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>5621 Jordan Road</b> |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Public Relations</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Alcoa</b> |
| 13a. STATE<br><b>Maryland</b>   |                         |   |  | 13b. COUNTY<br><b>Montgomery</b>   | 13c. CITY OR TOWN<br><b>Bethesda</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>W. N. St. Peter</b>  |                         |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Edith Kelly</b>  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>yes</b>   |                         | (IF YES, GIVE WAR OR DATES)<br><b>WW II</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>192-07-7653</b>   |  | 17. INFORMANT<br><b>John M. St. Peter, Jr.</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Chronic Alcoholism</b><br><b>3030</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost:<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF   |                         |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH      |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1  |                         |   |  |  |  |   |   |
| 19a. DATE OF OPERATION  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |   |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |   |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |   |  |  |  |   |   |
| ACTUAL SIGNATURE<br><b>John G. Ball</b>   |                         | TITLE (SPECIFY)<br><b>Deputy</b>  |  | MEDICAL EXAMINER   |  | DATE SIGNED<br><b>June 29, 1981</b>   |   |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>John G. Ball, M.D.</b>   |                         | ADDRESS<br><b>7936 Old Georgetown Road Bethesda, Maryland 20014</b>   |  |  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |                         | 23b. DATE<br><b>July 2, 1981</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cheltenham Veterans Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cheltenham, Maryland</b>                       |   |
| 24. FUNERAL DIRECTOR'S NAME<br><b>Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland</b>   |                         |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 8 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |   |

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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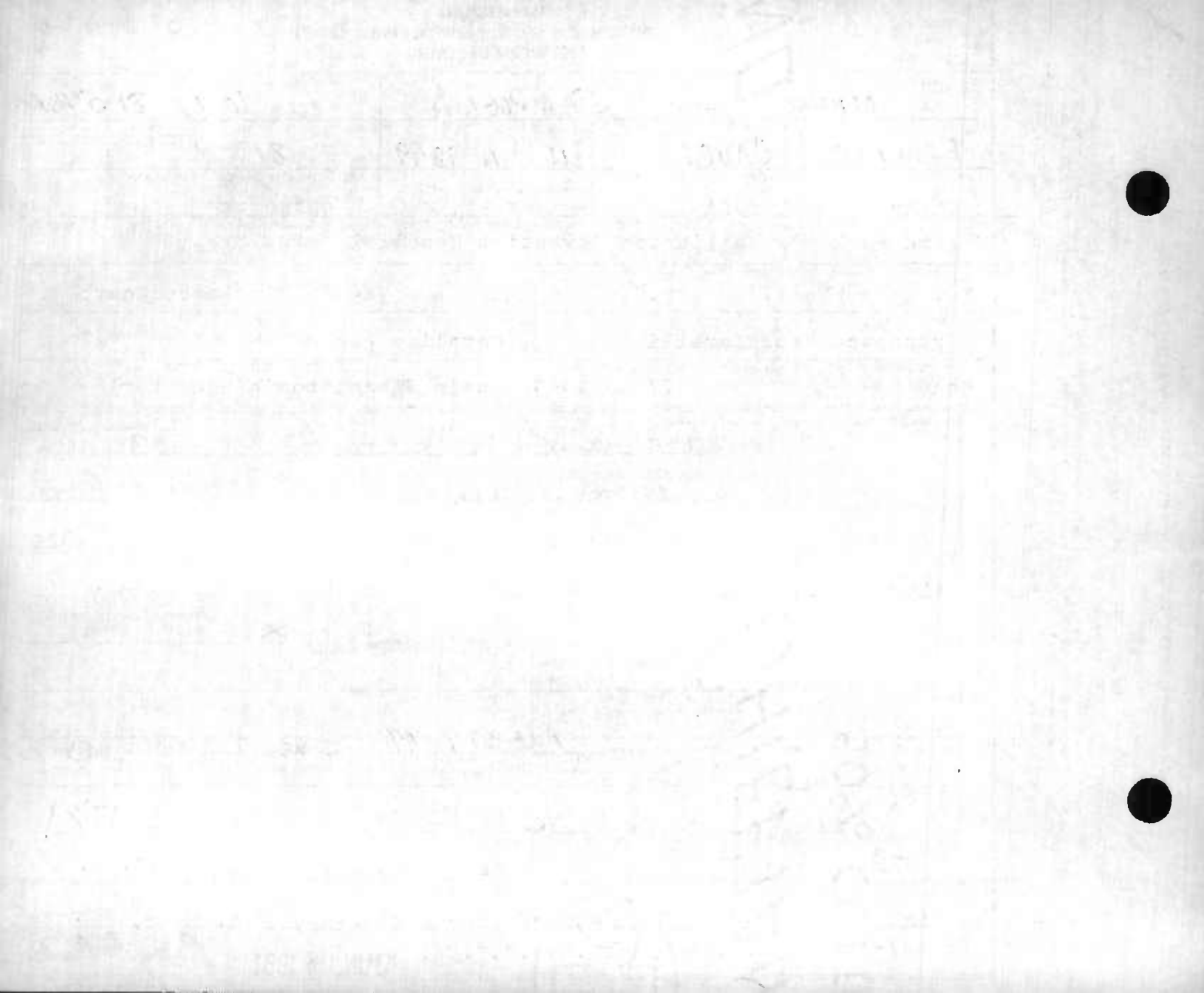


TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |  |                                    |  |  |                           |   | 8 1 1 6 4 3 5   |  |
|--|--|---|--|--|------------------------------------|--|--|---------------------------|---|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  |  |                                    |  |  |                           |   | REG. NO.  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |   |  |  | 2a. DATE OF DEATH                  |  |  |                           |   | 2b. HOUR  |  |
| FIRST MARY (Maria) MIDDLE LAST SAMPOLNA  |  |   |  |  | MONTH 6 DAY 17 YEAR 81             |  |  |                           |   | 5:40 AM   |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH   |                                    | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR           |   | IF UNDER 24 HRS   |  |
| FEMALE   |  | CAUC.   |  | MONTH 11 DAY 11 YEAR 99  |                                    | 81 YRS   |  | MONTHS DAYS               |   | HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?                            |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |                           |   |   |  |
| Italy  |  | USA   |  |  |                                    | Montgomery MD.   |  |                           |   |   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION |  |  |                                    |  |  |                           |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  |
| Takoma Park  |  | Washington Adventist Hospital                           |  |  |                                    |  |  |                           |   | Housewife   |  |
| 13a. STATE   |  |   |  |  | 13b. COUNTY                        |  | 13c. CITY OR TOWN                              |                           | 13d. INSIDE CITY LIMITS?  |   |  |
| Md.  |  |   |  |  | Mont.                              |  | S.S.   |                           | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 14. FATHER'S NAME  |  |   |  |  | 15. MOTHER'S MAIDEN NAME           |  |  |                           |   |   |  |
| FIRST MIDDLE LAST Francesco Vecchiarelli   |  |   |  |  | FIRST MIDDLE LAST Carolina Paolo   |  |  |                           |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES)   |  |   |  |  | 16b. SOCIAL SECURITY NO.           |  | 17. INFORMANT                                  |                           |   |   |  |
| NONE   |  |   |  |  | 577 48 2063                        |  | Same as above<br>Susie Giannantonio (Daughter) |                           |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:  |  |   |  |  |                                    |  |  |                           |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                  |  |
| IMMEDIATE CAUSE (a) 4310 ventricular fibrillation  |  |   |  |  |                                    |  |  |                           |   | 30 min  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) hemorrhage acute  |  |   |  |  |                                    |  |  |                           |   | 3-4 hrs   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) rupture (2) Corbical Artery   |  |   |  |  |                                    |  |  |                           |   | 3-4 hrs   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: mild renal insufficiency, possible sepsis, leucocytosis   |  |   |  |  |                                    |  |  |                           |   |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED |  |                                    | 20a. AUTOPSY?  |  |                           | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |   |  |
|  |  |   |  |  |                                    | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |                           | YES <input type="checkbox"/> NO <input type="checkbox"/>            |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY                              |  |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)  |  |                           |   |   |  |
|  |  |   | HOUR A.M. MONTH DAY YEAR                         |  |                                    |  |  |                           |   |   |  |
| 21d. INJURY OCCURRED   |  |   | 21e. PLACE OF INJURY                             |  |                                    | 21f. LOCATION  |  |                           |   |   |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |   | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |                                    | CITY OR TOWN COUNTY STATE  |  |                           |   |   |  |
| 22a. I certify that (1) this hospital attended the deceased from August 9, 1981, to June 17, 1981, that (2) we lost saw the deceased alive on June 16, 1981, and that in (3) our opinion death occurred on the date and hour and from the causes stated above (1) (2) (3) (did, did not, saw the body after death) |  |   |  |  |                                    |  |  |                           |   |   |  |
| 22b. SIGNATURE   |  |   |  |  |                                    | DEGREE   |  |                           | 22c. DATE SIGNED  |   |  |
| John Kijak Jr. M.D.  |  |   |  |  |                                    | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |                           | 6-17-81   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  |  |                                    | 22e. ADDRESS   |  |                           |   |   |  |
| John Kijak   |  |   |  |  |                                    | 344 University Blvd. W. S.S.Md.  |  |                           |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |   | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY |  |  | 23d. LOCATION             |   |   |  |
| Burial   |  |   | 6/20/81  |  | Gate of Heaven Cemetery            |  |  | CITY OR TOWN COUNTY STATE |   |   |  |
|  |  |   |  |  |                                    |  |  | S.S. Mont. Mdr.           |   |   |  |
| 24. FUNERAL DIRECTOR   |  |   |  |  |                                    | 25a. DATE REC'D. BY REGISTRAR  |  |                           | 25b. REGISTRAR'S SIGNATURE  |   |  |
| Hines/Rinaldi F.H.11800 N.H.Ave.S.S.Md.  |  |   |  |  |                                    | JUN 18 1981  |  |                           | Rinaldi   |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BH

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |   |  |   |  |  |  | 8  | 1 | 1  | 6  | 4   | 3 | 6  |  |
|---|--|--|--|---|--|---|--|--|--|--|---|--|--|---|---|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   |  |   |  |  |  | REG. NO.   |   |  |  |   |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>BESSIE RADUSIN SANDERS</b>   |  |  |  |   |  |   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>JUNE 6, 1981</b>  |   |  |  | 2b. HOUR<br><b>6:15<sup>P</sup> M</b>   |   |  |  |
| 3. SEX<br><b>FEMALE</b>   |  |  | 4. RACE<br><b>WHITE</b>  |   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>SEPT 28, 1920</b>   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>60</b> YRS                     |  |   | IF UNDER 1 YEAR MONTHS DAYS                      |  | IF UNDER 24 HRS HOURS MIN.  |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY COUNTY MD.</b> |  |   |  |  |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BETHESDA</b>  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE CLINICAL CENTER</b> |   |  |   |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>X-Ray Technician</b>                                   |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Hospital</b> |   |   |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  |  |  |   |  |   |  |  |  | 13b. COUNTY<br><b>Montgomery</b>   |   | 13c. CITY OR TOWN<br><b>Bethesda</b>             |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>6605 Tusculum Road</b> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Michael Radusin</b>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Amelia Mrksich</b>  |   |  |  |  |  |   |  |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>Yes</b>   |  |  |  |   | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br><b>WW II</b> |   | 17. INFORMANT ADDRESS<br><b>MS. KAREN SANDERS 6605 TUSCULUM RD BETHESDA, MD. 20034</b> |  |  |  |   |  |  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1749 Pulmonary failure with acute cor pulmonal</b><br>IMMEDIATE CAUSE (a)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Metastatic breast carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)              |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>hours</b>   |   |  |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |   |  |   |  |  |  |  |   |  |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |  |   |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)       |  |  |   |  |  |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                       |  |  |   |  |  |   |   |  |  |
| 22a. I certify that (this hospital) attended the deceased from <b>MAY 8, 1981</b> , to <b>JUNE 6, 1981</b> , that (we) last saw the deceased alive on <b>JUNE 6, 1981</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |  |  |  |   |  |  |   |   |  |  |
| 22b. SIGNATURE<br><i>[Signature]</i>  |  |  |  |   |  |   |  |  |  | DEGREE   |   | 22c. DATE SIGNED<br><b>6/7/81</b>                |  |   |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Sumner Hill</b>   |  |  |  |   |  |   |  |  |  | 22e. ADDRESS<br><b>NATIONAL INSTITUTES OF HEALTH CLINICAL CENTER, BETHESDA, MARYLAND 20205</b>                             |   |  |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |  |  | 23b. DATE<br><b>June 9 1981</b>                                     |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National</b>   |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>  |   |  |  |   |   |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Robert A. Pumphrey</b><br><b>Homes, P.A.</b>  |  |  |  |   |  | 24b. ADDRESS<br><b>Bethesda, Maryland</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 11 1981</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i> |  |   |   |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the hospital, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a report filed.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |   |   |   |   |  |
|--|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>EVELYN D. SANTULLO</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JUNE 25, 1981</b>                     |   | 2b. HOUR<br>A. <b>10:30 M</b>  |
| 3. SEX<br><b>FEMALE</b>  | 4. RACE<br><b>WHITE</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 01 1918</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. <b>62</b>                               |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Holy Cross Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Maid</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Hotel</b>  |
| 13a. STATE<br><b>VA.</b>   |   | 13b. COUNTY<br><b>Arlington</b>   | 13c. CITY OR TOWN<br><b>ARLINGTON</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>2250 N. Quincy Street</b>  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Nicholas DePompa</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Sabatini</b>   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>108-05-3351</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Lea Sherman (daughter)</b>                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bronchogenic carcinoma</b><br><b>1629</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>(massive hemoptysis)</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 mos</b>   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |   |   |   |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6/25 19 81</b> to <b>6/25 19 81</b> that (I) (we) last saw the deceased alive on <b>6/25 19 81</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |   |   |   |   |  |
| 22b. SIGNATURE<br><b>Barry N. Rosenbaum, M.D.</b>  |   | DEGREE<br><b>M.D.</b>   |   | 22c. DATE SIGNED<br><b>6/25/81</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BARRY N. ROSENBAUM</b>   |   | 22e. ADDRESS<br><b>3720 FARRAGUT AVE.<br/>KENSINGTON, MD. 20795</b>   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>Jun. 30, 1981</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sts. Peter &amp; Paul Cem.</b>         |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Elmira, New York</b>  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Ives Funeral Home,</b>  |   | ADDRESS<br><b>Arlington, VA.</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 2 1981</b>  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |

10-20-50

DATE

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SUBJECT

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |               |  |                                    |   |                                       |  |   |  |  |
|--|--|--|---------------|--|------------------------------------|---|---------------------------------------|--|---|--|--|
| 1. FOR STATE REGISTRAR   |  |  |               |  | 7 1 1 6 4 3 8                      |   |                                       |  |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |               |  | 2a. DATE OF DEATH                  |   |                                       |  |   |  |  |
| Delia Evangeline Sarelas   |  |  |               |  | June 17, 1981                      |   |                                       |  |   |  |  |
| 3. SEX   |  | 4. RACE  |               | 5. DATE OF BIRTH   |                                    | 6. AGE  |                                       | 7b. HOUR   |   |  |  |
| Female   |  | Caucasian  |               | Dec 26 1884  |                                    | 96 YRS.   |                                       | 11:50 A  |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |               | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |                                       |  |   |  |  |
| Greece   |  | USA  |               |  |                                    | Montgomery MD.  |                                       |  |   |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |               |  |                                    | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |                                       | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |  |
| Kensington   |  | Kensington Gardens N.H.  |               |  |                                    | Housewife   |                                       | N/C  |   |  |  |
| 13a. STATE   |  |  |               |  | 13b. COUNTY                        |   | 13c. CITY OR TOWN                     |  | 13d. INSIDE CITY LIMITS?  |  |  |
| Maryland   |  |  |               |  | Montgomery                         |   | Laytonsville                          |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME  |  |  |               |  | 15. MOTHER'S MAIDEN NAME           |   |                                       |  |   | 13e. STREET ADDRESS  |  |
| Thomas Economakos  |  |  |               |  | Stathoola (UNK)                    |   |                                       |  |   | 20608 Farcroft Lane  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |               |  | 16b. SOCIAL SECURITY NO.           |   | 17. INFORMANT                         |  |   |  |  |
| No   |  |  |               |  | 006-03-2476A                       |   | Beatrice Karambellas/Daughter /as 13e |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |               |  |                                    |   |                                       |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |               |  |                                    |   |                                       |  |   |  |  |
| IMMEDIATE CAUSE (a) SEPTICEMIA   |  |  |               |  |                                    |   |                                       |  |   | 1 DAY  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) URINARY TRACT INFECTION   |  |  |               |  |                                    |   |                                       |  |   | 1 month  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |               |  |                                    |   |                                       |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |               |  |                                    |   |                                       |  |   |  |  |
| SENILITY   |  |  |               |  |                                    |   |                                       |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  |               | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                    |   |                                       | 20a. AUTOPSY?  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |  |               |  |                                    |   |                                       | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |               | 21b. TIME OF INJURY  |                                    |   |                                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |  |
|  |  |  |               | HOUR A.M. MONTH DAY YEAR   |                                    |   |                                       |  |   |  |  |
| 21d. INJURY OCCURRED   |  |  |               | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)   |                                    |   |                                       | 21f. LOCATION  |   |  |  |
| WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  |               |  |                                    |   |                                       | CITY OR TOWN COUNTY STATE  |   |  |  |
| 22a. I certify that I (as hospital) attended the deceased from 6/11/81 to 6/17/81, that I (we) last saw the deceased alive on 6/11/81 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If deceased, did not) view the body after death. |  |  |               |  |                                    |   |                                       |  |   |  |  |
| 22b. SIGNATURE   |  |  |               | DEGREE   |                                    |   |                                       | 22c. DATE SIGNED   |   |  |  |
| Thos G. WARD   |  |  |               | MD   |                                    |   |                                       | 6/17/81  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |               | 22e. ADDRESS   |                                    |   |                                       |  |   |  |  |
| Thos G. WARD   |  |  |               | 6116 Robinwood Bethesda, 20831   |                                    |   |                                       |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  | 23b. DATE     |  | 23c. NAME OF CEMETERY OR CREMATORY |   |                                       | 23d. LOCATION  |   |  |  |
| Burial   |  |  | June 19, 1981 |  | Gate of Heaven Cem.                |   |                                       | Silver Spring Montgomery Md.   |   |  |  |
| 24. FUNERAL DIRECTOR   |  |  |               | 25a. DATE REC'D. BY REGISTRAR  |                                    |   |                                       | 25b. REGISTRAR'S SIGNATURE   |   |  |  |
| Hines/Rinaldi F.H.   |  |  |               | 11800 New Hampshire Ave Silver Spring, Md.   |                                    |   |                                       | JUN 22 1981  |   |  |  |





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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |               |   |   |  |  |  |   |  | REG. NO. 16439                               |               |  |  |
|---|--|---------------|---|---|--|--|--|---|--|--|---------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) John Henry Sartain  |  |               | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR 6 26 19 81  |   |  | 2b. HOUR M 15  |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR 6 26 19 81 |  |  | 2d. HOUR M 15 |  |  |
| 3. SEX male   |  | 4. RACE white |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR Sep. 9 1897 83 |  | 6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.  |  | 7. IF UNDER 1 YR. MONTHS DAYS                         |  | 7. IF UNDER 24 HRS. HOURS MIN                |               |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D.C.   |  |               | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.   |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County                                   |  |               |  |  |
| 10. CITY OR TOWN OF DEATH Olney   |  |               | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret.-Grounds Keeper-   |  |   | 12b. KIND OF BUSINESS OR INDUSTRY Galudet College)                                       |  |               |  |  |
| 13a. STATE Md.  |  |               | 13b. COUNTY Pr. Geo.  |   |  | 13c. CITY OR TOWN New Carrollton   |  |   | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |               | 13e. STREET ADDRESS 8605-Preston St., New                        |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST Henry Sartain  |  |               | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST Mary Ellen White  |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No  |  |   | 16b. SOCIAL SECURITY NO. 578-62-6603M  |  |               | 17. INFORMANT ADDRESS (Son) 8605-Preston St., New Carrollton Md. |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning<br>9108<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) DUE TO, OR AS A CONSEQUENCE OF  |  |               |   |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |               |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1  |  |               |   |   |  |  |  |   |  |  |               |  |  |
| 19a. DATE OF OPERATION  |  |               | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |  |  |  |   | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>         |  |               |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |               | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6/26/81  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) fell into swimming pool  |  |   |  |  |               |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  |               | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home  |   |  | 21f. LOCATION 17728 Striley Dr. Silver Spring Mont. Co. Md.  |  |   |  |  |               |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural cause <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |               |   |   |  |  |  |   |  |  |               |  |  |
| ACTUAL SIGNATURE H. R. Guard  |  |               | TITLE (SPECIFY) Assistant   |   |  | DATE SIGNED 6/28/81  |  |   | M.D. MEDICAL EXAMINER  |  |               |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.   |  |               | ADDRESS 111 Penn Street, Balto., MD 21201   |   |  |  |  |   |  |  |               |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial  |  |               | 23b. DATE 6/30/1981   |   |  | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.  |  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE Brantwood Pr. Geo. Md.                           |  |               |  |  |
| 24. FUNERAL DIRECTOR NAME Nalley's F.H. Inc.  |  |               | ADDRESS Mt. Rainier, Md.  |   |  | 25a. DATE REC'D. BY REGISTRAR JUL 2 1981   |  |   | 25b. REGISTRAR'S SIGNATURE   |  |               |  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |  |   |  |
|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Edward J. Schaefer   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>June 12, 1981                         |   | 2b. HOUR<br>7:55 PM  |
| 3. SEX<br>Male  | 4. RACE<br>Caucasian  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Feb 4, 1904   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>77 YRS.                                   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                  |
| 7a. BIRTHPLACE<br>WASHINGTON, D.C.  | 7b. CITIZEN OF WHAT COUNTRY?<br>United States   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.                       |   |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>NOT IN SUCH FACILITY, GIVE STREET ADDRESS<br>9509 Montgomery Drive |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Salesman | 12b. KIND OF BUSINESS OR<br>Automotive Supply   |  |
| 13a. STATE<br>Maryland  |   | 13b. COUNTY<br>Montgomery   | 13c. CITY OR TOWN<br>Bethesda  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Michael D. Schaefer   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Margaret Hess  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>577-10-83004   | 17. INFORMANT<br>ADDRESS<br>Ellen J. Schaefer (Same as 13e)                  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pulmonary abscess</u><br>1629<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Probable Cancer of the lung</u><br>(c) <u>Chronic Obstructive Lung Disease</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c):<br><u>Chronic Obstructive Lung Disease</u> |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>6 weeks<br>APPROX - 2 YRS. |
| 19a. DATE OF OPERATION<br>—   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>—   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>1978</u> , to <u>June</u> , 19 <u>81</u> , that (I) ( <del>we</del> ) lost saw the deceased alive on <u>12 June</u> , 19 <u>81</u> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>not</del> ) view the body after death.   |   |   |  |   |  |
| 22b. SIGNATURE<br><u>Augustus A. Aquino</u>   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br>13 June 81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Augustus A. Aquino, MD</u>  |   | 22e. ADDRESS<br><u>10401 Old Georgetown Rd. MD.</u>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |   | 23b. DATE<br>June 16, 1981  | 23c. NAME OF CEMETERY OR CREMATORY<br>Ft. Lincoln Cemetery                   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Bladensburg Maryland         |
| 24. FUNERAL DIRECTOR<br>NAME<br>Robert A. Pumphrey<br>Homes, P.A., Bethesda, Maryland   |   |   | 25a. DATE REC'D. BY REGISTRAR<br>JUN 19 1981                                 |   |  |
|   |   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Robert A. Pumphrey</u>                      |   |  |

MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Cleared by M.E. 12 June 81 R. B. Davis

4402



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.DHMH - 16 50M 1/B1  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|
| 1- FOR<br>STATE<br>REGISTRAR  |  |  |  |  | 8 1 1 6 4 4 1  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  |  |  | 2a. DATE OF DEATH  |  |  | 2b. HOUR   |  |
| Annie T. Schuster   |  |  |  |  | June 13 1981   |  |  | 3:23 P M   |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | 7. IF UNDER 1 YEAR   |  |
| Female  |  | White  |  | Sept. 3 1901   |  | 79   |  | MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |  |
| Wash., D. C.  |  | USA  |  |  |  | Montgomery MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| Bethesda  |  | Suburban Hospital  |  |  |  | Adm. Asst. -   |  | IRS  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |  | 13b. INSIDE CITY LIMITS?                                 |  | 13c. STREET ADDRESS  |  |  |
| D.C.  |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 1716 31st Street, S. E.                                    |  |  |
| 14. FATHER'S NAME   |  |  |  |  | 15. MOTHER'S MAIDEN NAME                                 |  |  |  |  |
| Charles Tresselt  |  |  |  |  | Katherine Loeffler                                       |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  |  | 16b. SOCIAL SECURITY NO.                                 |  | 17. INFORMANT  |  |  |
| No  |  |  |  |  |  |  | 253 Sharptown Rd., Laurel, Md.<br>J. Richard Schuster, Son |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>4100 IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <u>ASCVD</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>                    |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED |  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY                              |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |
|   |  |  | HOUR A.M. MONTH DAY YEAR<br>P.M. 19              |  |  |  |  |  |  |
| 21d. INJURY OCCURRED  |  |  | 21e. PLACE OF INJURY                             |  |  | 21f. LOCATION  |  |  |  |
| WHILE <input type="checkbox"/> NO: WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  | CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10-14</u> , 19 <u>79</u> , to <u>6-12</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>5-22</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (I) did not view the body after death) |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE  |  |  |  |  |  | DEGREE   |  | 22c. DATE SIGNED   |  |
|   |  |  |  |  |  |  |  | 6-15-81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  |  |  | 22e. ADDRESS   |  |  |  |
| Dr. Daniel M. Howell  |  |  |  |  |  | 4400 Stamp Rd., Marlow Heights, Md.  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY                       |  | 23d. LOCATION  |  |  |
| Burial  |  |  | 6-17-81  |  | Cedar Hill Cem.  |  | Suitland, P.G., Maryland                                   |  |  |
| 24. FUNERAL DIRECTOR  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. BY WHOM SIGNED  |  |
| NAME Robt E Wilhelm ADDRESS 4308 Suitland Rd., Suitland, Md.  |  |  |  |  |  | JUN 18 1981  |  |  |  |

MEDICAL CERTIFICATION

BP

2 21:3



1981



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |               |   |   |  |                            |  |  |  |  | REG. NO. 16442   |  |
|---|---------------|---|---|--|----------------------------|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |               | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Edward J. Sharp  |   |  |                            |  |  |  |  | 2a. DATE KNOWN OF DEATH ESTI-MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 06 19 81 |  |
| 3. SEX Male   | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 08-24-06  | 6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS. | IF UNDER 1 YR. MONTHS DAYS   | IF UNDER 24 HRS. HOURS MIN | 2c. DATE PRONOUNCED DEAD 06 19 81  |  | 2d. HOUR 11 PM   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York  |               | 7b. CITIZEN OF WHAT COUNTRY? United States  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery  |  | MD   |  |  |  |
| 10. CITY OR TOWN OF DEATH Bethesda  |               | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital |   |  |                            | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Printer                        |  | 12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.                                    |  |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |               |   |   |  |                            |  |  |  |  |  |  |
| 13a. STATE Maryland   |               | 13b. COUNTY Montgomery  |   | 13c. CITY OR TOWN Rockville  |                            | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS 199 Rollins Ave.   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Hugh Sharp  |               |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hannah Conlin   |                            |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No   |               |   |   | 16b. SOCIAL SECURITY NO. 081-05-5903   |                            | 17. INFORMANT ADDRESS Victoria S. Rymer Bethesda, Md.  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u><br>4110 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Cardio Vascular Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |               |   |   |  |                            |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).   |               |   |   |  |                            |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |               |   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                            |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |               |   |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |                            | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |               |   |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |                            | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |               |   |   |  |                            |  |  |  |  |  |  |
| ACTUAL SIGNATURE <u>John G. Ball</u>  |               |   |   | TITLE (SPECIFY) M.D. Deputy  |                            |  |  | DATE SIGNED June 20, 1984  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) John G. Ball  |               |   |   | ADDRESS 1936 Old Georgetown Rd. Bethesda, Maryland   |                            |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL Burial  |               |   |   | 23b. DATE June 23, 1981  |                            | 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery                                   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Maryland Silver Spring,                  |  |  |  |
| 24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland   |               |   |   |  |                            | 25a. DATE REC'D. BY REGISTRAR JUN 25 1981  |  | 25b. REGISTRAR'S SIGNATURE <u>Robert A. Pumphrey</u>                             |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the office of the Registrar within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Item 5 85557 7/8/81 83

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 6 4 4 3

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |  |  |  |
|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Elwood K. Shaw</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>June 26, 1981</b>                                |  | 2b. HOUR<br><b>3:48 P.M.</b>   |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>CAUCASIAN</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>FEB 14 1930</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>51</b>   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>VA.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.                                      |  |
| 10. CITY OR TOWN OF DEATH<br><b>SILVER SPRING</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>HOLY CROSS HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING YEARS)<br><b>ASST. ENGINEER</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>WOODNER</b>  |
| 13a. STATE<br><b>MD</b>   |   |   | 13b. COUNTY<br><b>PRINCE GEORGE ADELPHI</b>  | 13c. CITY OR TOWN<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>        | 13d. INSIDE CITY LIMITS?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> |
| 14. FATHER'S NAME<br><b>BRYAN L. SHAW</b>   |   | 15. MOTHER'S MAIDEN NAME<br><b>BERTA M. SHAW</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES IF UNKNOWN) <b>YES</b> (IF YES, GIVE DATES) <b>KOREAN</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>230-34-0828</b>  |  | 17. INFORMANT<br><b>DOROTHY M. SHAW</b> ADDRESS<br><b>SAME AS 13 E</b>                             |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic renal cell carcinoma</b><br>1890<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6+ months</b> |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)<br><b>Bleeding gastric ulcer and tumor invasion of duodenum c</b>  |   |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>April 15, 1981</b>   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>6-26</b>   |  | 20a. AUTOPSY?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>   |   |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)                     |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I, this hospital) attended the deceased from <b>April 15, 1981</b> , to <b>6-26, 1981</b> that (I, we) last saw the deceased alive on <b>6-26, 1981</b> and that in (my, our) opinion death occurred on the date and hour and from the causes stated above, (I, we) did not move the body after death.   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Jason Beiger MD</b>  |   | DEGREE  |  | 22c. DATE SIGNED<br><b>6-27-81</b>   |  |
| 22d. PHYSICIAN'S NAME - (TYPE OR PRINT)   |   | 22e. ADDRESS<br><b>8830 CAMERON ST<br/>SILVER SPRING MD 20910</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |   | 23b. DATE<br><b>6-30-81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>PLEASANT GROVE CEM.</b>                                   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>INDEPENDENCE GRAYSON VA.</b>   |   |   |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>FRANCIS J. COLLINS</b>   |   | 500 UNIVERSITY BLVD. WEST<br>SILVER SPRING, MD  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 30 1981</b>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |   |   |  |  |  |

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1970-11-11 STANLEY H. STANLEY AS 11.1

FRANCIS J. COLLINS  
STANLEY SPRING

200 UNIVERSITY BLVD. WEST  
JUN 20 1981

JUN 20 1981

STANLEY H. STANLEY AS 11.1

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WHEN 172 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |  |                  |  |   |  |  |  |  |  |  |  |  |  |                |  |  |  |  |  |
|--|--|------------------|--|---|--|--|--|--|--|--|--|--|--|----------------|--|--|--|--|--|
| 1. FOR<br>1- STATE REGISTRAR   |  |                  |  |   |  |  |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 2b. HOUR          |  |  |  |                |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) George N. Shaw  |  |                  |  |   |  |  |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 2b. HOUR          |  |  |  |                |  |  |  |  |  |
| 3. SEX M   |  | 4. RACE W        |  | 5. DATE OF BIRTH MONTH DAY YEAR Feb 12 1958   |  | 6. AGE (IN YEARS) LAST BIRTHDAY 58 YRS.  |  | IF UNDER 1 YR. MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD June 15, 1981   |  | 2d. HOUR 11:30 |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Alabama  |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.                       |  |                |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH Olney  |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret-Bureau Chief   |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY H.E.W.   |  |                |  |  |  |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                  |  |   |  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |                |  |  |  |  |  |
| 13a. STATE Md  |  | 13b. COUNTY Mont |  | 13c. CITY OR TOWN Silver Spring   |  | 13e. STREET ADDRESS 14615 Crossway Road Rockville, Md. 20853                   |  |  |  |  |  |  |  |                |  |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST James --- Shaw   |  |                  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lena --- Norris  |  |  |  |  |  |  |  |  |  |                |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes   |  |                  |  | 16b. SOCIAL SECURITY NO. WW I 215-44-2594   |  | 17. INFORMANT ADDRESS Aubrey D. Shaw, 14615 Crossway Road Rockville, Md. 20853 |  |  |  |  |  |  |  |                |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days                                   |  |                  |  |   |  |  |  |  |  |  |  |  |  |                |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <u>Fracture L hip</u>  |  |                  |  |   |  |  |  |  |  |  |  |  |  |                |  |  |  |  |  |
| 19a. DATE OF OPERATION 6-1-81  |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <u>Fracture L hip</u>   |  |  |  |  |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH   |  |                  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5:28 PM 1981   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <u>Fell into room</u>  |  |  |  |  |  |                |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <u>Nursing Home</u>   |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE <u>Rockville Mont Md</u>  |  |  |  |  |  |                |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                  |  |   |  |  |  |  |  |  |  |  |  |                |  |  |  |  |  |
| ACTUAL SIGNATURE <u>John S. Rogers</u>   |  |                  |  | TITLE (SPECIFY) M.D. <u>Doc</u>   |  |  |  | MEDICAL EXAMINER   |  |  |  | DATE SIGNED June 15/1981   |  |                |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers   |  |                  |  | ADDRESS Silver Spring, Montgomery County, Md.   |  |  |  |  |  |  |  |  |  |                |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial   |  |                  |  | 23b. DATE 6/18/81   |  | 23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park                      |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland                                  |  |  |  |                |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc.   |  |                  |  |   |  | 25a. DATE REC'D. BY REGISTRAR JUN 18 1981                                      |  |  |  | 25b. REGISTRAR'S SIGNATURE <u>Harry Heberly</u>  |  |  |  |                |  |  |  |  |  |
| 5130 Wisconsin Ave., NW, Washington, D.C. 20016  |  |                  |  |   |  |  |  |  |  |  |  |  |  |                |  |  |  |  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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|  |  |   |  |
|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO.  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Irene Edith Shaw   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>June 2, 1981  |  |
| 3. SEX<br>Female   |  | 2b. HOUR<br>7:36 P M  |  |
| 4. RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>April 26, 1921   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>60   |  |
| 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County MD  |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Clinical Center, NIH, Beth., Md.   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Secretary  |  |
| 12b. BUSINESS OR INDUSTRY<br>Chas. Riddle Const. Co.   |  |   |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Montgomery   |  |
| 13c. CITY OR TOWN<br>Kensington  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Robert Bettinelli   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Rose Battaglia  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>no  |  | 16b. SOCIAL SECURITY NO.<br>181-16-0656   |  |
| 17. INFORMANT ADDRESS<br>Mr. Lucian Shaw (husband) same as patient   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Intracerebral</u><br>2875 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Thrombocytopenia</u><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>84 Hours<br>2 Months                 |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>Myeloproliferative Disorder</u>   |  |   |  |
| 19a. DATE OF OPERATION<br>05/19/81   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Splenectomy & liver biopsy; liver enlarged  |  |
| 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                |  |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 27, 1981 to June 2, 1981, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on June 2, 1981, and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) <del>not</del> view the body after death. |  |   |  |
| 22b. SIGNATURE<br>Alan R. Baker  |  | 22c. DATE SIGNED<br>6/3/81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ALAN R. BAKER   |  | 22e. ADDRESS<br>National Institutes of Health<br>Clinical Center, Bethesda, Md. 20205   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>6-6-1981   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Fort Lincoln   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Brentwood Pr. Georges, Md.   |  |
| 24. FUNERAL DIRECTOR<br>Warner E. Pumphrey, Inc.<br>8434 Ga. Ave., S.S. Md.  |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 9 1981   |  |
| 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |   |  |

24. FUNERAL DIRECTOR

25a. DATE REC'D. BY REGISTRAR

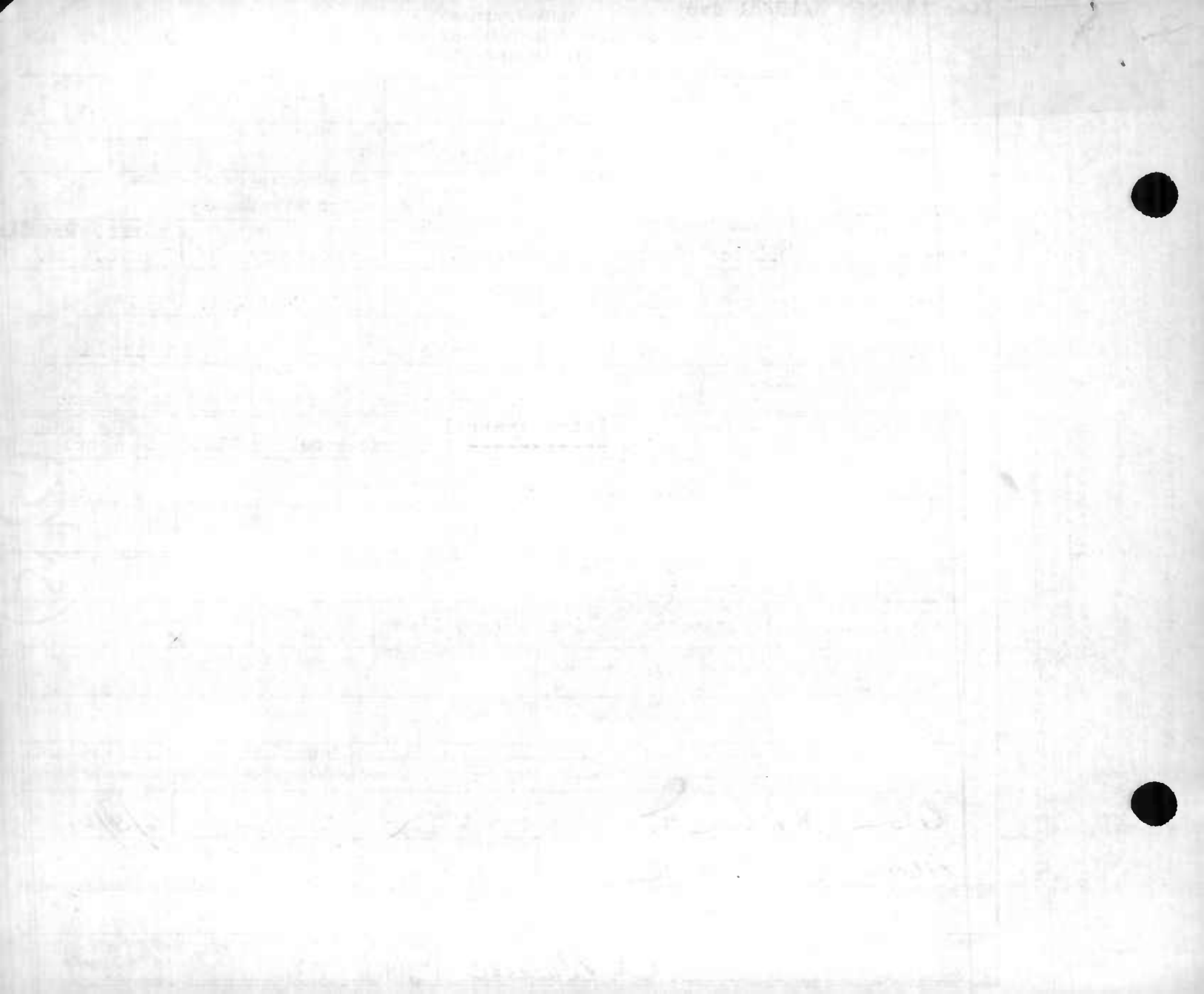
25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

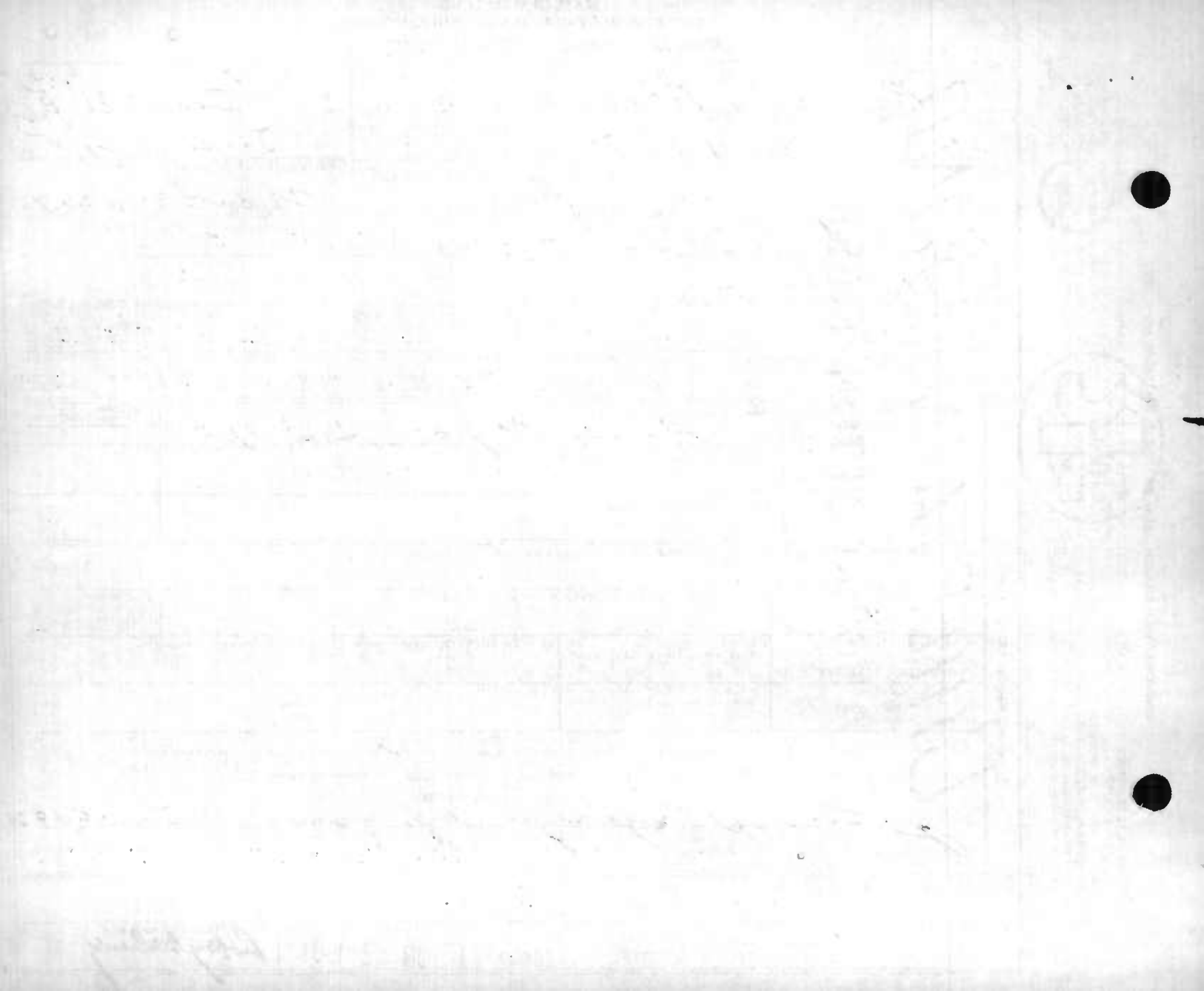
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR OUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR<br>STATE<br>REGISTRAR   |  |                  |  |  |  |  |  |   |  |                                 |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |   |   |  |  |   |  |  |  |  |  |  | REG. NO. 16446                      |  |  |  |
|---|--|------------------|--|--|--|--|--|---|--|---------------------------------|--|---|---|---|--|--|---|--|--|--|--|--|--|-------------------------------------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Remond Peter Sheinman</i>  |  |                  |  |  |  |  |  |   |  |                                 |  | 2a. DATE KNOWN OF DEATH <i>June 17, 1981</i>  |   |   |  |  |   |  |  |  |  |  |  | 2b. HOUR OF ESTI. MATED <i>8 PM</i> |  |  |  |
| 3. SEX <i>M</i>   |  | 4. RACE <i>W</i> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <i>Jan 11 30 51</i>   |  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS. MONTHS DAYS HOURS MIN. <i>51</i> |   |  | IF UNDER 1 YR. IF UNDER 24 HRS. |  |   | 2c. DATE PRONOUNCED DEAD <i>June 17, 1981</i> |   |  |  | 2d. HOUR OF PRONOUNCED DEAD <i>8 PM</i> |  |  |  |  |  |  |                                     |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>U.S.S.R.</i>   |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>   |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                 |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery MD.</i>                          |   |   |  |  |   |  |  |  |  |  |  |                                     |  |  |  |
| 10. CITY OR TOWN OF DEATH <i>72nd Park</i>  |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Advent Hosp</i> |  |  |  |   |  |                                 |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>CONSULTANT</i>     |   |   |  | 12b. KIND OF BUSINESS OR INDUSTRY <i>COMPUTER FIRM</i>                                       |   |  |  |  |  |  |  |                                     |  |  |  |
| 13a. STATE <i>MD</i>  |  |                  |  |  |  |  |  |   |  |                                 |  | 13b. COUNTY <i>Montgomery</i>   |   | 13c. CITY OR TOWN <i>Silver Spring</i>                                |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS <i>273 HANNIS STREET</i> |  |  |  |  |  |                                     |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <i>ELYA-PEISACH SHEINMAN</i>   |  |                  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <i>SIMA L. LEIBOVICH</i> |  |   |  |                                 |  |   |   |   |  |  |   |  |  |  |  |  |  |                                     |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <i>NO</i>   |  |                  |  |  |  | 16b. SOCIAL SECURITY NO. <i>218-80-8525</i>                            |  |   |  |                                 |  | 17. INFORMANT ADDRESS <i>MARIANNE MAY SHEINMAN SAME AS 13 WIFE</i>                  |   |   |  |  |   |  |  |  |  |  |  |                                     |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarct</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. <i>4291</i><br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |                  |  |  |  |  |  |   |  |                                 |  |   |   |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |  |  |                                     |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><i>None</i>  |  |                  |  |  |  |  |  |   |  |                                 |  |   |   |   |  |  |   |  |  |  |  |  |  |                                     |  |  |  |
| 19a. DATE OF OPERATION <i>None</i>  |  |                  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                      |  |   |  |                                 |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |   |  |  |   |  |  |  |  |  |  |                                     |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>         |  |   |  |                                 |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)       |   |   |  |  |   |  |  |  |  |  |  |                                     |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |                  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)            |  |   |  |                                 |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                   |   |   |  |  |   |  |  |  |  |  |  |                                     |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                  |  |  |  |  |  |   |  |                                 |  |   |   |   |  |  |   |  |  |  |  |  |  |                                     |  |  |  |
| ACTUAL SIGNATURE <i>John S. Rogers</i>  |  |                  |  |  |  | TITLE (SPECIFY) <i>cap</i>   |  |   |  |                                 |  | MEDICAL EXAMINER  |   |   |  |  |   | DATE SIGNED <i>June 18, 1981</i>             |  |  |  |  |  |                                     |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) <i>JOHN S. ROGERS</i>  |  |                  |  |  |  | ADDRESS <i>1919 SEMINARY ROAD, SILVER SPRING, MD.</i>                  |  |   |  |                                 |  |   |   |   |  |  |   |  |  |  |  |  |  |                                     |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <i>CREMATION</i>   |  |                  |  |  |  | 23b. DATE <i>6/22/81</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY <i>METROPOLITAN CREMATORY</i>  |  |                                 |  |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <i>ALEXANDRIA VIRGINIA</i> |  |  |   |  |  |  |  |  |  |                                     |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <i>FRANCIS J. COLLINS</i>  |  |                  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <i>JUN 22 1981</i>                       |  |   |  |                                 |  | 25b. REGISTRAR'S SIGNATURE <i>Harry M. ...</i>                                      |   |   |  |  |   |  |  |  |  |  |  |                                     |  |  |  |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901   |  |                  |  |  |  |  |  |   |  |                                 |  |   |   |   |  |  |   |  |  |  |  |  |  |                                     |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |  |  |   |  |  |   | 8  | 1 | 1   | 6                                 | 4                             | 4 | 7 |
|--|--|--|--|--|--|---|--|--|---|--|---|---|-----------------------------------|-------------------------------|---|---|
| 1 - FOR STATE REGISTRAR  |  |  |  |  |  |   |  |  |   | REG. NO.   |   |   |                                   |                               |   |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Gladys S. SHERWOOD</b>  |  |  |  |  |  |   |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>June 7, 1981</b>   |   |   |                                   | 2b. HOUR<br><b>6:45A</b>      |   |   |
| 3. SEX<br><b>Female</b>  |  |  | 4. RACE<br><b>White</b>  |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April 8, 1892</b>  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>88</b> YRS                  |  |   | IF UNDER 1 YEAR<br>MONTHS DAYS                |                                   | IF UNDER 24 HRS<br>HOURS MIN. |   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery Co.</b> MD. |  |   |   |                                   |                               |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Chevy Chase</b>  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bethesda Retirement &amp; Nursing Ctr.</b> |  |  |   |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>                                       |   |   | 12b. KIND OF BUSINESS OR INDUSTRY |                               |   |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |  |  |   |  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |   | 13e. STREET ADDRESS<br><b>1811 Blaine Dr.</b> |                                   |                               |   |   |
| 13a. STATE<br><b>Maryland</b>  |  |  | 13b. COUNTY<br><b>Montgomery</b>   |  |  | 13c. CITY OR TOWN<br><b>Chevy Chase</b>   |  |  |   |  |   |   |                                   |                               |   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Samuel Stewart</b>  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Alwilda Bowen</b>   |  |  |   |  |   |   |                                   |                               |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>577-22-1728D</b>   |  | 17. INFORMANT ADDRESS<br><b>705 Americana Dr., Apt. 23</b><br><b>Wilma P. Roberts, Annapolis, Md. 21403</b>  |   |  |   |   |                                   |                               |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b><br><b>4140</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>arteriosclerotic heart disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost |  |  |  |  |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 week</b>  |   |   |                                   |                               |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |   |  |  |   |  |   |   |                                   |                               |   |   |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |                                   |                               |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |   |   |                                   |                               |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |   |   |                                   |                               |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6/2/81</b> 19 <b>1969</b> , to <b>6/7/81</b> 19____, that (I) (we) lost saw the deceased alive on <b>6/2/81</b> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |   |  |  |   |  |   |   |                                   |                               |   |   |
| 22b. SIGNATURE<br><b>Jeremy V. Cooke MD</b>  |  |  |  |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>June 7, 1981</b>  |   |   |                                   |                               |   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Jeremy V. Cooke, M.D.</b>  |  |  |  |  |  |   |  | 22e. ADDRESS<br><b>10400 Conn. Ave., Kensington, Md.</b>   |   |  |   |   |                                   |                               |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |  |  | 23b. DATE<br><b>June 10, 1981</b>                                      |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Damascus Meth.</b>   |  |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Damascus, - Montgomery, Md.</b>   |   |   |                                   |                               |   |   |
| 24. FUNERAL DIRECTOR<br>NAME <b>Olin L. Molesworth, P.A., Damascus, Md.</b>  |  |  |  |  |  |   |  | DATE REC'D. BY REGISTRAR<br><b>JUN 15 1981</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Patricia Belmont</b>  |   |   |                                   |                               |   |   |

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |  |  |   |  |  |  |   |   |  |
|---|--|--|--|---|--|--|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>GUY DEXEY SHIFFLETT  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>June 7, 1981                    |   |  | 2b. HOUR<br>1:30 P.M.  |  |   |   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Caucasian   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>July 12, 1948   |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br>32 YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>United States  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY Co. MD.                           |  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Suburban Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Clerk            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>U.S. Gov't   |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland  |  |  |  |   | 13b. COUNTY<br>Montgomery                                      |  | 13c. CITY OR TOWN<br>Bethesda                                    |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Claude E. Shifflett   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary C. Mayor |  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>219-48-3509  |  | 17. INFORMANT<br>ADDRESS<br>Claude E. Shifflett (Same as 13e)   |  |  |  |   |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>careless arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>congestive heart failure + pulmonary infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>polymyositis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:<br>45 min<br>72 hrs<br>3 months |  |  |  |   |  |  |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I       |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 <u>79</u> to <u>6-7</u> 19 <u>81</u> , that (I) (we) lost<br>saw the deceased alive on <u>6-7</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |   |   |  |
| 22a. SIGNATURE<br>John D. Allin M.D.  |  |  |  |   | DEGREE   |  | 22c. DATE SIGNED<br>6-8-81                                       |   |   |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br>John D. Allin M.D.   |  |  |  |   | 22e. ADDRESS<br>8218 Wisconsin Ave Bethesda, Md. 20014.        |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  |  | 23b. DATE<br>June 11, 1981   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Parklawn Mem. Park       |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Rockville Maryland |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Robert A. Humphrey<br>Homes, P.A., Bethesda, Maryland   |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>JUN 15 1981                   |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]                        |   |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cardiopulmonary, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |  |  |   |  |  |  |                            |
|--|--|---|--|--|--|---|--|--|--|----------------------------|
| CERTIFICATE OF DEATH   |  |   |  |  |  |   |  |  |  |                            |
| 1. FOR<br>STATE<br>REGISTRAR   |  |   |  |  | REG. NO.   |   |  |  |  |                            |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MOLTARAM SHIRAZI</b>  |  |   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>6.9.81</b>  |   |  |  |  | 2b. HOUR<br><b>4:00 PM</b> |
| 3 SEX<br><b>F</b>  |  | 4 RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1--1--17</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b> YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.    |  |                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Iran</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><input checked="" type="checkbox"/> <b>Iran</b>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                    |  |  |  |                            |
| 10 CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Suburban Hospital</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>-----</b>                  |  |                            |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |  |  |   |  |  |  |                            |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Montgomery</b>  |  | 13c. CITY OR TOWN<br><b>Rockville</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1719 Lorre Drive</b>                     |  |                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Ezra Darvish</b>  |  |   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Morvarid Beinie</b>  |   |  |  |  |                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>219-80-4802</b>   |  | 17. INFORMANT ADDRESS<br><b>Rockville, Md.<br/>Mike Shirazi; 1719 Lorre Dr.,</b>   |  |   |  |  |  |                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |   |  |  |  |   |  |  |  |                            |
| PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiogenic Shock</b>   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>12 HOURS</b> |  |                            |
| 4100 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last   |  |   |  |  |  |   |  | 12 HOURS   |  |                            |
| DUE TO, OR AS A CONSEQUENCE OF<br>b) <b>Acute Myocardial Infarction</b>  |  |   |  |  |  |   |  | 12 HOURS   |  |                            |
| DUE TO, OR AS A CONSEQUENCE OF<br>c) <b>Atherosclerotic coronary disease</b>   |  |   |  |  |  |   |  | Years  |  |                            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Diabetes mellitus</b>   |  |   |  |  |  |   |  |  |  |                            |
| 19a. DATE OF OPERATION<br><b>8/9/81</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Diabetes mellitus</b>  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |                            |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |                            |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |                            |
| 22a. I certify that (I) this hospital attended the deceased from <b>8/9/81</b> to <b>6/9/81</b> , that (II) (we) lost <b>8/9/81</b> now the deceased alive on <b>8/9/81</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |  |  |                            |
| 22b. SIGNATURE<br><b>Samuel Itscovitz</b>  |  |   |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  | 22c. DATE SIGNED<br><b>6/9/81</b>                                  |  |                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SAMUEL ITSCOVITZ</b>   |  |   |  |  | 22e. ADDRESS<br><b>5632 SHIELDS DRIVE Bethesda</b>   |   |  |  |  |                            |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>June 10, 1981</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Nat'l. Mem. Park</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Falls Church, Va.</b>                          |  |  |  |                            |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Danzansky-Goldberg Chapels; 1170 Rockville Pike</b>   |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 15 1981</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |  |                            |

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Montgomery

Butler's Suburban Hospital

Interpretation of results

1946-47

1947-48

1948-49

1949-50

1950-51

1951-52

TO HOSPITAL-ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must also be filed at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |  |  |  |   |  |  |
|---|--|--|--|--|--|--|---|--|--|
| 8 1 1 6 4 5 0<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |   |  |  |
| REG. NO.  |  |  |  |  |  |  |   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Sarah F. Shoemaker</b>   |  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>June 23, 1981</b>                                    |  | 2b. HOUR<br><b>5 25</b><br>A M                |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Caucasian</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>October 17, 1988</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>92</b> YRS.  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN  |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 9. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>  |  | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 11. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.   |   |  |  |
| 12. CITY OR TOWN OF DEATH<br><b>Bethesda, M.D.</b>  |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bethesda Health Center</b> |  |  |  | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>  |   | 15. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  |  |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>D.C.</b> 13b. COUNTY <b>Washington</b> 13c. CITY OR TOWN <b>Washington</b>   |  |  |  |  | 14. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 15. STREET ADDRESS<br><b>4005-64th Street</b> |  |  |
| 16. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Benjamin Hamilton</b>  |  |  |  |  | 17. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>(Unknown) Snider</b>                       |  |   |  |  |
| 18a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 18b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>578-10-5514</b>  |  | 19. NAME AND ADDRESS<br><b>Engene H. Shoemaker 6002-Wilmet Rd.<br/>Bethesda, Maryland</b>  |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>stroke</b><br><b>4360</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 wk</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):<br><b>Organic brain syndrome</b>   |  |  |  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____ 19 <b>79</b> , to <b>6-23</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>6-17</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.    |  |  |  |  |  |  |   |  |  |
| 22b. SIGNATURE<br><b>James Brodsky MD</b>   |  | DEGREE <b>MD</b>   |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>6-23-81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>James Brodsky MD</b>  |  |  |  | 22e. ADDRESS<br><b>4701 Wilard Ave Chevy Chase 20015</b>   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>  |  | 23b. DATE <b>June 26, 1981</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Fort Lincoln Cem.</b>   |  | 23d. LOCATION<br>CITY & TOWN COUNTY STATE<br><b>Bladensburg Maryland</b>   |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Robert A. Humphrey Funeral Homes, P.A., Bethesda, Maryland</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 29 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert A. Humphrey</b>  |   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |   |  |  |  |  | 8 1 1 6 4 5 1              |  |
|---|--|---|--|---|---|--|--|--|--|----------------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  |   |  |   | CERTIFICATE OF DEATH                                    |  |  |  |  |                            |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   |  |   | 2a. DATE OF DEATH                                       |  |  |  |  | 2b. HOUR                   |  |
| BESSIE (BETTY)  |  |   |  |   | JUNE 5 81   |  |  |  |  | 8:00 AM                    |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |   | 6. AGE   |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS.           |  |
| Female  |  | White   |  | APR. 6 01   |   | 80 YRS.  |  | MONTHS DAYS  |  | HOURS MIN.                 |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |  |                            |  |
| ILLINOIS  |  | U.S.A.  |  |   |   | MONTGOMERY MD.   |  |  |  |                            |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |                            |  |
| ROCKVILLE   |  | 14639 BAUER DR.   |  |   |   | HOUSEWIFE  |  |  |  |                            |  |
| 13a. STATE  |  |   |  |   | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?                                       |                            |  |
| MD  |  |   |  |   | MONTGOMERY  |  | ROCKVILLE  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                            |  |
| 14. FATHER'S NAME   |  |   |  |   | 15. MOTHER'S MAIDEN NAME                                |  |  |  |  |                            |  |
| FRANK   |  |   |  |   | AMELIA  |  |  |  |  | LUHAN                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |   |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES) |  | 17. INFORMANT ADDRESS                                    |  |  |                            |  |
| NO  |  |   |  |   | 340-24-9976   |  | LOUIS STIBAL -HUSBAND- SAME AS 13c                       |  |  |                            |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) congestive heart failure<br>4/40<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) arteriosclerotic heart disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 yr<br>yr |  |   |  |   |   |  |  |  |  |                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br>Stress ulcers   |  |   |  |   |   |  |  |  |  |                            |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                            |  |
|   |  |   |  |   |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1976 to 1981, that (I) (we) lost saw the deceased alive on 5/1/81, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.  |  |   |  |   |   |  |  |  |  |                            |  |
| 22b. SIGNATURE<br>Jeremy V. Cooke MD  |  |   |  |   | DEGREE<br>MD  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>6/5/81 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Jeremy V. Cooke  |  |   |  |   | 22e. ADDRESS<br>10400 Conn Ave Kensington               |  |  |  |  |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  |   | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY                      |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |                            |  |
| BURIAL  |  |   | JUN. 8, 1981   |   | GATE OF HEAVEN  |  |  | SILVER SPRING MONT. MD.  |  |                            |  |
| 24. FUNERAL DIRECTOR<br>NAME FRANCIS J. COLLINS<br>ADDRESS 500 UNIVERSITY BLVD., W. SILVER SPRING, MD.  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR                           |  | 25b. REGISTRAR'S SIGNATURE                               |  |  |                            |  |
|   |  |   |  |   | JUN 12 1981   |  | [Signature]  |  |  |                            |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |  |                                   |
|---|--|---|---|--|-----------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Walter C. Simmons</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6 7 81</b>                                  |  | 2b. HOUR<br><b>9:00 AM</b>        |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>Black</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 25 86</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS HOURS MIN.<br><b>94</b>          |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County MD.</b>                 |                                   |
| 10. CITY OR TOWN OF DEATH<br><b>Wheaton</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Manor Care Wheaton</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Pharmacist</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE<br><b>District of Columbia</b>   |  | 13b. CITY OR TOWN<br><b>20001</b>   | 13c. STREET ADDRESS<br><b>207 S Street N.W. Wash DC</b>                               |  |                                   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>   |   |  |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>unknown</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>216-32-2298</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>JAMES H. KENNEDY, 12202 Hunter Lane, Rockville MD</b> |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PROSTATIC ADENOCARCINOMA - widely metastatic</b><br><b>1850</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  |   |   |  |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):<br><b>TRANSITIONAL CELL CARCINOMA OF THE BLADDER - LOCALLY INVASIVE</b>   |  |   |   |  |                                   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |                                   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/14/81</b> to <b>6/7</b> , 19 <b>81</b> , that (I) (we) lost <b>5/14/81</b> above, (I) (we) (did) (did not) view the body after death.   |  |   |   |  |                                   |
| 22b. SIGNATURE<br><b>Bryan J. Arling</b>  |  | DEGREE  |   | 22c. DATE SIGNED<br><b>6/7/81</b>  |                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BRYAN J. ARLING M.D.</b>  |  | 22e. ADDRESS<br><b>1145 19 ST NW #407 WASH. D.C. 20036</b>  |   |  |                                   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>11 Jun 81</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lincoln Memorial Cem.</b>                   |                                   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Suitland, P. G. Co. Maryland</b>   |  | 24. FUNERAL DIRECTOR<br>NAME<br><b>W. Ernest Jarvis Co., Inc., Washington, D.C.</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 18 1981</b>                                  |                                   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Rebecca H. H. H.</b>   |  |   |   |  |                                   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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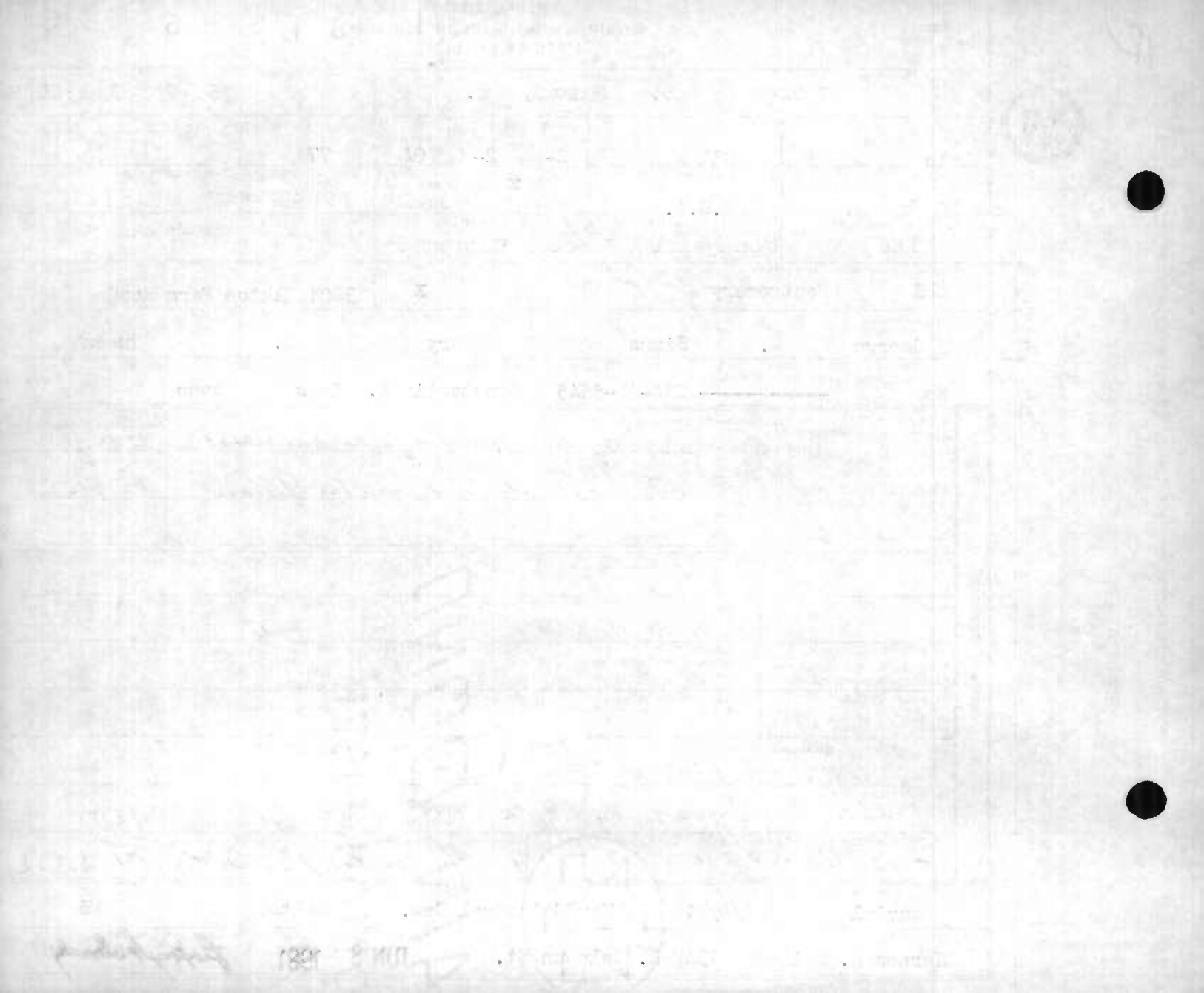
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |   |   |   |  |  |  |
|--|--|--|--|---|---|---|--|--|--|
| 1- FOR STATE REGISTRAR   |  |  |  |   | REG. NO. 8 1 1 6 4 5 3  |   |  |  |  |
| 1 DECEASED NAME (TYPE OR PRINT)  |  |  |  |   | 2a DATE OF DEATH MONTH DAY YEAR                                     |   |  |  |  |
| George E. Simms, Sr.   |  |  |  |   | 6 2 81  |   |  |  |  |
| 3 SEX  |  | 4 RACE   |  | 5. DATE OF BIRTH MONTH DAY YEAR   |   | 6 AGE (IN YEARS LAST BIRTHDAY)          |  | 7b HOUR                                      |  |
| Male   |  | Blk  |  | 2- 2- 04  |   | 77 YRS                                  |  | 1:00AM                                       |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b CITIZEN OF WHAT COUNTRY?  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH     |  | 10b IF UNDER 24 HRS MONTHS DAYS HOURS MIN.   |  |
| MA   |  | U.S.A.   |  |   |   | montgomery                              |  | MD.  |  |
| 10 CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |   |   |  |  |  |
| Olney  |  | Montgomery General Hospital  |  |   |   |   |  |  |  |
| 12a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   | 13d INSIDE CITY LIMITS?   |   | 13e STREET ADDRESS   |  |  |
| 12b STATE  |  |  |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 3801 Elkton Farm Road  |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST   |  |  |  |   | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                           |   |  |  |  |
| George W. Simms  |  |  |  |   | Mary E. Queen   |   |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  |   | 16b SOCIAL SECURITY NO.   |   | 17. INFORMANT ADDRESS  |  |  |
| No   |  |  |  |   | 214-40-5545   |   | Constantia L. Simms same                                       |  |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:  |  |  |  |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| IMMEDIATE CAUSE (a) <u>Coronary insufficiency &amp; cardiac arrest</u>   |  |  |  |   |   |   |  | 3 hrs  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |   |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |  |  |   |   |   |  | 15 yrs                                       |  |
| b) <u>Arteriosclerotic cardiovascular disease</u>  |  |  |  |   |   |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |   |   |  |  |  |
| (c) _____  |  |  |  |   |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  |  |  |   |   |   |  |  |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a AUTOPSY?  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |
|  |  |  |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |  |  |  |
|  |  | P.M. 19  |  |   |   |   |  |  |  |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f LOCATION STREET   |   | CITY OR TOWN                            |  | COUNTY STATE                                 |  |
|  |  |  |  |   |   |   |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from Jan 19 60 to June 19 81, that (I) (we) lost saw the deceased alive on June 1 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |  |  |   |   |   |  |  |  |
| 22b. SIGNATURE   |  |  |  |   | DEGREE  |   |  | 22c. DATE SIGNED                             |  |
| A.D. BOHIFANT  |  |  |  |   | M.D.  |   |  | 6/2/81                                       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  |   | 22e ADDRESS   |   |  |  |  |
| A.D. BOHIFANT  |  |  |  |   | 1811 Prince Philip Dr. Olney, Md. 20832                             |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE |  |  |  |
| Burial   |  | 6/6/81   |  | New Cathedral Cem.  |   | Balto MD                                |  |  |  |
| 24 FUNERAL DIRECTOR NAME ADDRESS   |  |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR           |  | 25b. REGISTRAR'S SIGNATURE                   |  |
| Vernon R. Bailey 1348 N. Calhoun St.   |  |  |  |   |   | JUN 8 1981                              |  | Fifty-Nine                                   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |   |   |  |   |  |  |  |
|---|--|--|---|---|--|---|--|--|--|
| CERTIFICATE OF DEATH  |  |  |   |   |  |   |  |  |  |
| REG. NO.  |  |  |   |   |  |   |  |  |  |
| 1. FOR STATE REGISTRAR  |  |  |   |   | 2a. DATE OF DEATH                            |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |   |   | 2b. HOUR                                     |   |  |  |  |
| MORRIS K. SINGER  |  |  |   |   | June 12, 1981 9:01 A.M.                      |   |  |  |  |
| 3 SEX   |  | 4 RACE   |   | 5. DATE OF BIRTH  |  | 6 AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR  |  |
| Male  |  | White  |   | Nov. 10, 1906   |  | 74 YRS.   |  | MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH   |  |  |  |
| Pennsylvania  |  | USA  |   |   |  | Montgomery MD.  |  |  |  |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| Silver Spring   |  | Holy Cross Hospital  |   | Administrator   |  | US Weather Bureau   |  |  |  |
| 13a. STATE  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS  |  |
| Maryland  |  | Montgomery   |   | Sil. Spg.   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |  | 11649 Lockwood Drive   |  |
| 14 FATHER'S NAME  |  |  |   |   | 15 MOTHER'S MAIDEN NAME                      |   |  |  |  |
| Hyman A. Singer   |  |  |   |   | Tauba (unknown)                              |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT ADDRESS   |  |   |  |  |  |
| No  |  | ---  |   | 577-38-0338 Ron Singer; 11620 Lockwood Dr., SSpg Md.  |  |   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |   |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:  |  |  |   |   |  |   |  |  |  |
| IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>   |  |  |   |   |  |   |  |  | <u>Immediate</u>                             |
| 2500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |   |   |  |   |  |  |  |
| (b) <u>Acute myocardial infarction</u>  |  |  |   |   |  |   |  |  | <u>48 hrs</u>                                |
| (c) <u>Diabetic Mellitus</u>  |  |  |   |   |  |   |  |  | <u>34 yrs</u>                                |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Ketoadonosis - Electrolyte abnormalities</u>   |  |  |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                  |   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |  |   |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY   |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |  |  |
|   |  |  | HOUR A.M. MONTH DAY YEAR  |   |  |   |  |  |  |
|   |  |  | P.M. 19   |   |  |   |  |  |  |
| 21d. INJURY OCCURRED  |  |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY OFFICE, FARM, ETC.) |   |  | 21f. LOCATION   |  |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |   |   |  | STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>8/47</u> 19 <u>81</u> , to <u>6-12</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>6/12/81</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.) |  |  |   |   |  |   |  |  |  |
| 22b. SIGNATURE  |  |  |   |   | DEGREE                                       |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED                             |
| <u>William Kurstin MD</u>   |  |  |   |   |  |   |  |  | <u>6/12/81</u>                               |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |   |   | 22e. ADDRESS                                 |   |  |  |  |
| <u>William Kurstin, MD</u>  |  |  |   |   | <u>1145 19th St. N. W. Washington, D. C.</u> |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION   |  |  |  |
| Burial  |  | 6-14-81  |   | D. C. Lodge Cem.  |  | Washington, D.C.  |  |  |  |
| 24 FUNERAL DIRECTOR NAME  |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR                |   | 25b. REGISTRAR'S SIGNATURE   |  |  |
| <u>Danzansky-Goldberg Chapels; 1170 Rockville Pike</u>  |  |  |   |   | <u>JUN 16 1981</u>                           |   | <u>[Signature]</u>   |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |  |   |  |   |  |  |  |
|---|--|---|--|--|---|--|---|--|--|--|
| CERTIFICATE OF DEATH  |  |   |  |  |   |  |   |  |  |  |
| 1. FOR STATE REGISTRAR  |  |   |  |  | REG. NO.  |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>JOHN H arrison SIVLEY</b>   |  |   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>JUNE 6 81</b>   |  |   |  |  | 2b. HOUR <b>1430 P.M.</b>                    |
| 3 SEX <b>male</b>   |  | 4 RACE <b>Cauc.</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>10 06 18</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS.   |   | IF UNDER 1 YEAR MONTHS DAYS  |  | IF UNDER 24 HRS. HOURS MIN.                  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>TENN.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.                                   |   |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>ROCKVILLE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SHADY GROVE ADV. HOSPITAL</b> |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Priest</b>                  |   | 12b. KIND OF BUSINESS OR INDUSTRY <b>Religion</b>  |  |  |
| 13a. STATE <b>Maryland</b>  |  | 13b. COUNTY <b>Frederick</b>  |  | 13c. CITY OR TOWN <b>Mt. Airy</b>  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS <b>P.O. Box 416 21771</b>  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>John Harrison Sivley, Sr.</b>  |  |   |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret Holliday</b>   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>  |  | (IF YES, GIVE WAR OR DATES) <b>WW II Army</b>   |  | 16b. SOCIAL SECURITY NO. <b>413.16.3169</b>  |   | 17. INFORMANT ADDRESS <b>John S. Sivley--Same as 13e</b>                                     |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:   |  |   |  |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <b>arrhythmia</b>   |  |   |  |  |   |  |   |  |  | <b>30 minutes</b>                            |
| DUE TO, OR AS A CONSEQUENCE OF (b) <b>myocardial infarction</b>   |  |   |  |  |   |  |   |  |  | <b>4 weeks</b>                               |
| DUE TO, OR AS A CONSEQUENCE OF (c) <b>coronary atherosclerosis</b>  |  |   |  |  |   |  |   |  |  | <b>years</b>                                 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION <b>5-13-81</b>   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Complete Heart Block</b> |  |   | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>                  |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)          |  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>May 12</b> , 19 <b>81</b> , to <b>June 7</b> , 19 <b>81</b> , that (I) (we) lost <b>saw</b> the deceased alive on <b>June 6</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE <b>Mark F. Weinstein MD</b>  |  |   |  |  | DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   | 22c. DATE SIGNED <b>6/7/81</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARK F. WEINSTEIN MD</b>   |  |   |  |  | 22e. ADDRESS  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>  |  |   | 23b. DATE <b>6/8/1981</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Green Mount Crematory</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b> |  |  |  |
| 24. FUNERAL DIRECTOR NAME <b>Walter Brooks Bradley, Inc., Balto., Md. 21222</b>   |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR <b>JUN 9 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>                     |  |  |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                  |   |   |   |   |  |  |   | REG. NO. 16456  |  |
|--|--|------------------|---|---|---|---|--|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>PATRICIA A. SMITH   |  |                  |   |   |   |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br>6 9 19 81 |  | 2b. HOUR<br>M<br>10:13<br>P.M.                                |   |  |
| 3. SEX<br>female   |  | 4. RACE<br>Negro |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>07-18-43                        |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>37 YRS.  |  | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |   | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>6 9 19 81                             |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Wash., D.C.  |  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County MD. |   |  |
| 10. CITY OR TOWN OF DEATH<br>Takoma Park   |  |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Washington Adventist Hospital |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Unemployed                          |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>-----  |  |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE D.C.  |  |                  | 13b. CITY OR TOWN<br>Washington   |   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13d. STREET ADDRESS<br>4320 Kansas Ave., N.W.  |  |   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Sylester Turner  |  |                  |   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Agnes G. Barnes  |  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |  |                  | (IF YES, GIVE WAR OR DATES)   |   |   | 16b. SOCIAL SECURITY NO.<br>579-56-0747   |  | 17. INFORMANT ADDRESS<br>Agnes G. Price/Mother/224 R St., NW   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>9688 IMMEDIATE CAUSE (a) Multiple injuries<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |                  |   |   |   |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |  |                  |   |   |   |   |  |  |   |   |  |
| 19a. DATE OF OPERATION   |  |                  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                     |   |   |  |  |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |   | 21b. TIME OF INJURY<br>HOUR AM MONTH DAY YEAR<br>9:15 P.M. 6-9- 1981  |   |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Subject pushed into street & was struck by a van. |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |                  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>street |   |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>New Hampshire Ave. & Sligo Creek Pkwy. Montgomery Md.                         |   |   |  |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from Natural cause <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                  |   |   |   |   |  |  |   |   |  |
| ACTUAL SIGNATURE<br>   |  |                  |   | TITLE (SPECIFY)<br>M.D. Assistant                                     |   |   |  | MEDICAL EXAMINER   |   | DATE SIGNED<br>6-10-81  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Ann M. Dixon, M.D.   |  |                  |   | ADDRESS<br>111 Penn St.   |   |   |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  |                  |   | 23b. DATE<br>6/17/81  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>HARMONY MEM. PARK   |  |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Landover, Maryland                    |  |
| 24. FUNERAL DIRECTOR<br>MARSHALL'S FUNERAL HOME<br>4217 9th Street, N.W., Wash., D.C.  |  |                  |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br>JUN 16 1981  |  | 25b. REGISTRAR'S SIGNATURE<br>   |   |   |  |



*[Faint, illegible handwritten signature or text]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |  |  |   |  |  |
|---|--|---|--|---|--|--|---|--|--|
| FOR<br>1 - STATE<br>REGISTRAR   |  |   |  |   | 8 1 1 6 4 5 7  |  |   |  |  |
| CERTIFICATE OF DEATH  |  |   |  |   | REG. NO.   |  |   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CLARA S. SNELL</b>   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6-13-81</b>  |  |   | 2b. HOUR<br><b>3:25p</b> M   |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9-18-97</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b> YRS.                                    |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MINN.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY CO.</b> MD.                    |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>SILVER SPRING</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>HOLY CROSS HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md.</b> 13b. COUNTY <b>Montgomery</b> 13c. CITY OR TOWN <b>Takoma Pk.</b>   |  |   |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>7100 Poplar Ave</b> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Edward Strauss</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Kleinknecht</b>   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES AND OR UNKNOWN) <b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES) <b>None</b>   |  | 17. INFORMANT<br><b>George F. Snell-husband</b>   |  | ADDRESS <b>Takoma Pk, Md.<br/>7100 Poplar Ave</b>                                    |   |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4360</b> IMMEDIATE CAUSE (a) <b>Acute cerebrovascular accident</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>72 hrs</b> |  |   |  |   |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____  |  |   |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |  |
| 22a. I certify that (i) (this hospital) attended the deceased from <b>6/13/81</b> to <b>6/13/81</b> , that (i) (we) last saw the deceased alive on <b>6/13/81</b> , and that (ii) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (i) (we) (did) (did not) (sign) the body after death.  |  |   |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Myron L. Lenkin</b>  |  |   |  |   | 22c. ATTENDING MEDICAL STAFF<br>PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |  |   | 22d. DATE SIGNED<br><b>6/18/81</b>   |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MYRON L. LENKIN</b>   |  |   |  |   | 22f. ADDRESS<br><b>2309 SHOREFIELD RD<br/>WASHINGTON, MD</b>   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>14 June 1981</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lee's Crematory</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Washington, D.C. 20002</b>          |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Lee Funeral Home 300-4th St. N.E. Wash. D.C. 20002</b>   |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 17 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Kurtz</b>    |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 6 4 5 8

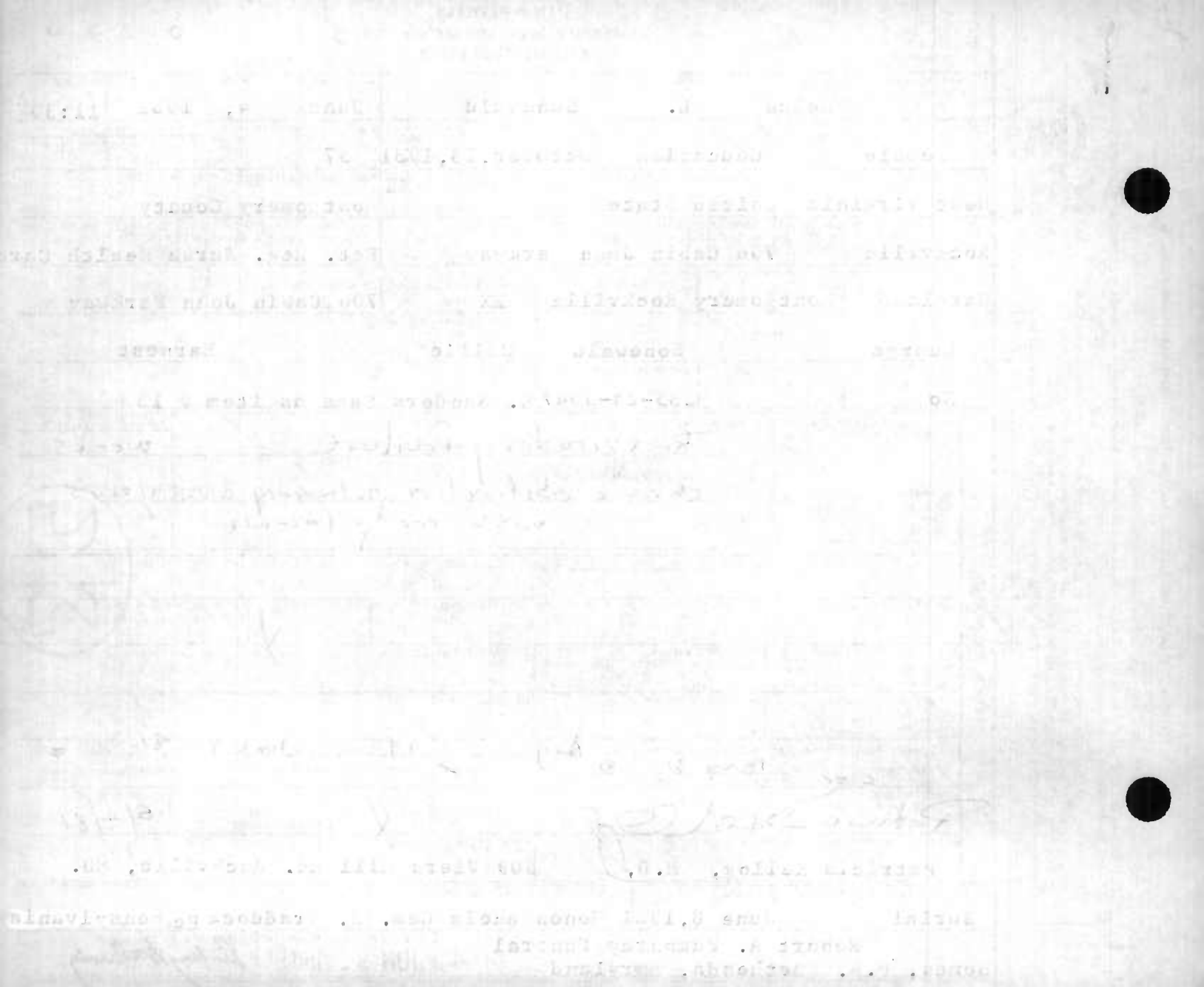
1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |  |                                     |  |  |
|---|--|--|--|--|-------------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Helen L. Sonewald</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>June 4, 1981</b> |  | 2b. HOUR<br>MIN.<br><b>11:30 AM</b> |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Caucasian</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>October 13, 1923</b>  |                                     | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>57</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>West Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                     | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County MD.</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rockville</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>706 Cabin John Parkway</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret. Reg. Nurse Health Care</b>   |                                     | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  |  |  | 13b. COUNTY<br><b>Montgomery</b>   |                                     | 13c. CITY OR TOWN<br><b>Rockville</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George Sonewald</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Nellie Earnest</b>   |                                     |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>235-24-5047</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>D. Sanders Same as item # 13</b>  |                                     |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>chronic obstructive pulmonary disease</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>with cor pulmonale</b><br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) |  |  |  |  |                                     |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>weeks</b> |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                                     |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                                     |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Aug 29</b> , 19 <b>79</b> , to <b>June 4</b> , 19 <b>81</b> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <b>May 31</b> , 19 <b>81</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did not) view the body after death.   |  |  |  |  |                                     |  |  |
| 22b. SIGNATURE<br><b>Patricia Kellogg</b>   |  |  |  | DEGREE<br><b>M.D.</b>  |                                     | 22c. DATE SIGNED<br><b>6/4/81</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Patricia Kellogg, M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>309 Viers Mill Rd. Rockville, MD.</b>   |                                     |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>June 8, 1981</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Monongahela Cem.</b>  |                                     | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>N. Braddock Pennsylvania</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 9 - 1981</b>   |                                     | 25b. REGISTRAR'S SIGNATURE<br><b>Lillian McBrady</b>   |  |

MEDICAL CERTIFICATION

BP



## CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |  |   |  |   |  |  |  |                                      |  |
|---|--|--|---|--|---|--|--|--|--------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>CLYDE HERBERT SORRELL SR.</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JUNE 1, 1981</b>            |  |   | 2b. HOUR<br><b>7:00 A M</b>  |  |  |                                      |  |
| 3 SEX<br><b>MALE</b>  |  | 4 RACE<br><b>WHITE</b>   |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>02 15 20</b>   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>61</b>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |                                      |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>WASH., D.C.</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD                                    |  |  |                                      |  |
| 10 CITY OR TOWN OF DEATH<br><b>OLNEY</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MONTGOMERY GENERAL HOSP.</b> |   |  |   | 12a. USUAL OCCUPATION<br>(INDUSTRY OF WORK)<br><b>NEWSPAPER RETIRED</b>                        |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>NEWSPAPER</b>  |                                      |  |
| 13a STATE<br><b>MARYLAND</b>  |  | 13b COUNTY<br><b>MONTG.</b>  |   | 13c CITY OR TOWN<br><b>GAITHERSBURG</b>  |   | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e STREET ADDRESS<br><b>20800 Goshen Road</b>   |                                      |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Henry - Sorrell</b>   |  |  |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Grace - Robinson</b>  |   |  |  |  |                                      |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>no</b>  |  |  |   | 16b SOCIAL SECURITY NO.<br><b>577-01-4133</b>  |   | 17 INFORMANT<br>ADDRESS<br><b>Clyde H. Sorrell, Jr. Damascus, Md. 20750</b>                    |  |  |                                      |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Hepatic Failure</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>DISSEMINATED SMALL CELL LUNG CARCINOMA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 days</b><br><b>3 MONTHS</b>   |                                      |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |  |   |  |   |  |  |  |                                      |  |
| 19a DATE OF OPERATION   |  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |   | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                      |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |                                      |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |  |  |                                      |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>MARCH</b> , 19 <b>81</b> , to <b>JUNE 1</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>MAY 31</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                   |  |  |   |  |   |  |  |  |                                      |  |
| 22b SIGNATURE<br><b>Eugene P. Flannery</b>  |  |  |   |  | DEGREE<br><b>JMD</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1 JUNE 81</b> |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>EUGENE P. FLANNERY</b>   |  |  |   |  | 22e ADDRESS<br><b>18111 PRINCE PHILIP DR - OLNEY, MD. 20832</b>               |  |  |  |                                      |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |  | 23b DATE<br><b>June 4, 1981</b>                                       |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>St. Paul Episcopal</b>                |  | 23d LOCATION<br>CITY OR TOWN P.G. COUNTY STATE<br><b>Baden P.G. Maryland</b>   |  |                                      |  |
| 24 FUNERAL DIRECTOR<br><b>Francis H. Barber Laytonsville, Md. 20760</b>   |  |  |   |  |   | 25a DATE REC'D. BY REGISTRAR<br><b>JUN 5 1981</b>  |  | 25b REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |                                      |  |

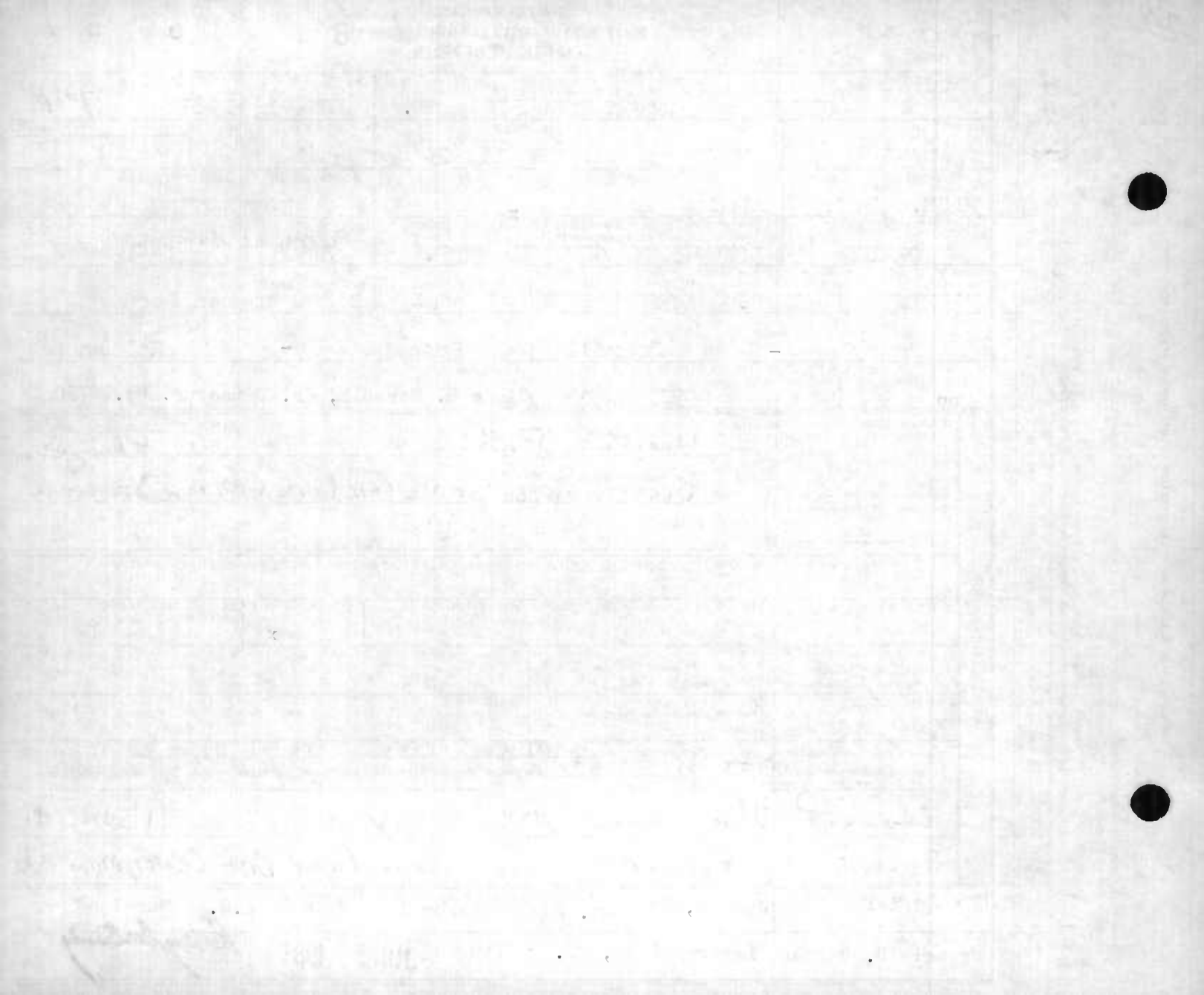
MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



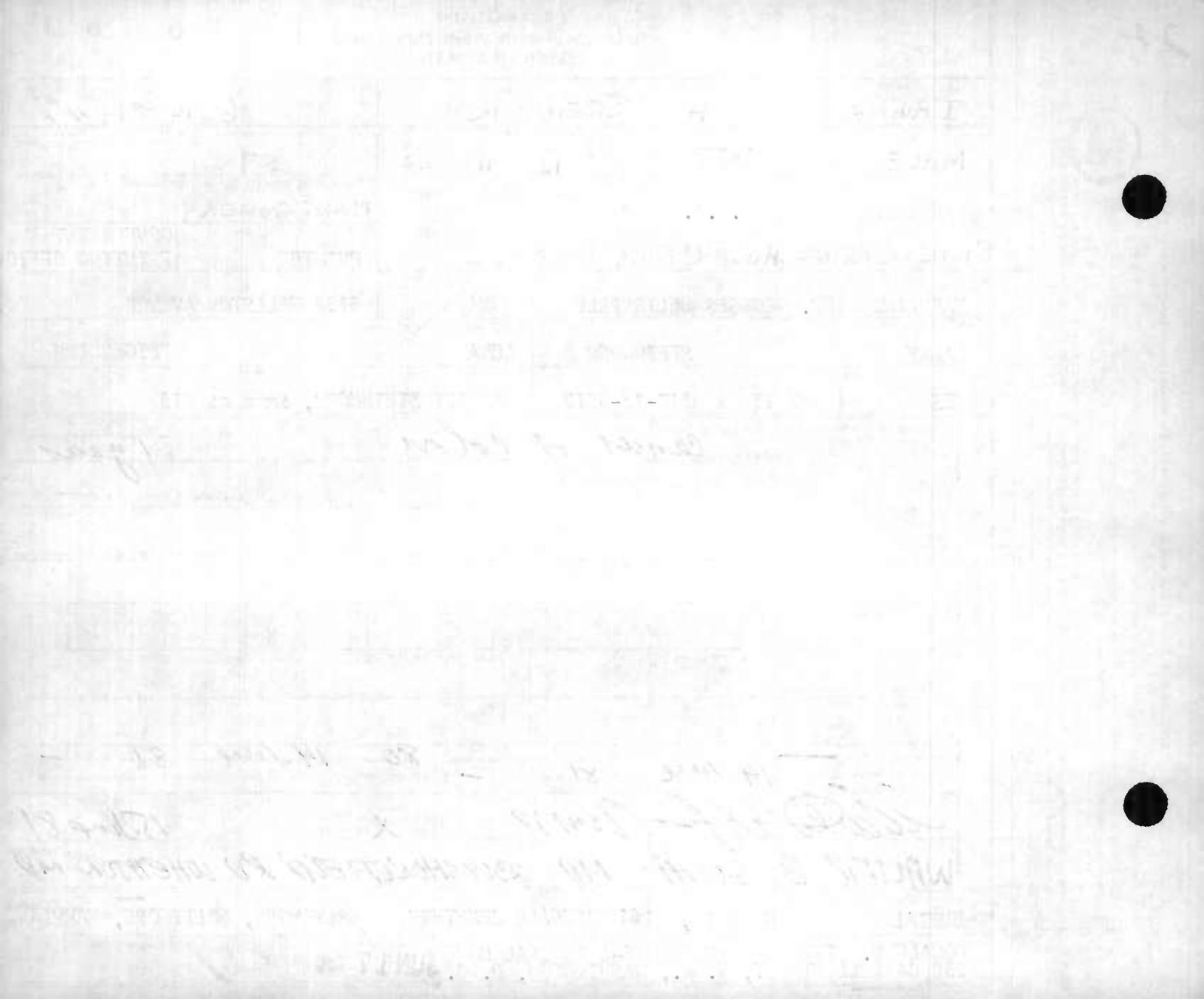


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and retained by the hospital or attending physician.

 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|
| 1 - FOR<br>STATE<br>REGISTRAR  |  | REG. NO. 8 1 1 6 4 6 0   |  |   |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>IRVING H. STEINHORN   |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>6 14 81  |  | 2b. HOUR<br>11 <sup>45</sup> P M   |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 11 23  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>57 YRS   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>SILVER SPRING   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>HOLY CROSS HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>PRINTER                     |  | 12b. INDUSTRY OR<br>PRINTING OFFICE  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MARYLAND 13b. COUNTY PR. GEORGES 13c. CITY OR TOWN BELTSVILLE   |  |  |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>3134 FALLSTON AVENUE  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>HARRY STEINHORN  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>LENA FEIGENBLUM  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>YES NO WW II   |  |  |  | 16b. SOCIAL SECURITY NO.<br>217-18-5517   |  | 17. INFORMANT<br>ADDRESS<br>HARRIET STEINHORN, same as #13                                      |  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 1539 Cancer of colon<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 year   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 16  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from 19 80 to 14 June 19 81, that (I) (we) last saw the deceased alive on 14 June 19 81, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did not) view the body after death.  |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Walter E. Goetz MD<br>DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |  |  |   |  | 22c. DATE SIGNED<br>15 June 81  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>WALTER E. GOETZ MD  |  |  |  |   |  | 22e. ADDRESS<br>2309 SHOREFIELD RD WHEATON MD   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  | 23b. DATE<br>JUNE 16, 1981   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>ROSEDALE CEMETERY   |  | 23d. LOCATION<br>BALTIMORE, BALTIMORE, MARYLAND   |  |  |  |
| 24. FUNERAL DIRECTOR<br>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME<br>232 CARROLL STREET, N. W., WASHINGTON, D. C.   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 17 1981  |  |  |  |

MEDICAL CERTIFICATION



5100 BP

DHMM - 16 50M 1/81  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |  |  |   |  |  |
|---|--|---|--|---|--|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ANDREW NMI STEVENSON   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>JUNE 10 1981                    |   |  | 2b. HOUR<br>9:30 P.M.   |  |  |   |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Caucasian  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>August 5, 1906  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 yrs   |  | 7. UNDER 5 YEAR<br>MONTHS DAYS   |   |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Illinois  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>United States                                     |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County MD.   |  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Silver Spring,   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>Holy Cross Hospital ER |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Economist                         |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>U.S. Gov't  |   |  |  |
| 13a. STATE<br>Maryland  |  |   | 13b. COUNTY<br>Montgomery  |   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>       |  |  | 13d. STREET ADDRESS<br>9208 Jones Mill Road             |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Andrew NMI Stevenson  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Genevieve Hardin      |   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No |  |  |   | 17. SOCIAL SECURITY NO.<br>220-44-6372   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION<br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) HYPERTENSIVE AND ARTERIOSCLEROTIC HEART DISEASE<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |   |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br>AORTIC VALVULAR STENOSIS AND INSUFFICIENCY  |  |   |  |   |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                        |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from APRIL 24 1981 to JUNE 10 1981, that (I) (we) last saw the deceased alive on APRIL 24 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |  |   |  |  |
| 22a. SIGNATURE<br>Robert L. Krichmar MD   |  |   |  |   |  | DEGREE<br>MD  |  | 22c. DATE SIGNED<br>JUNE 10 1981   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ROBERT L. KRICHMAR MD  |  |   |  |   |  | 22e. ADDRESS<br>7733 AUSTKA AVENUE N.W.<br>WASHINGTON D.C. 20012                                      |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |   | 23b. DATE<br>1981 Jun 15   |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>West Laurel Hill Cemetery                                       |  |  | 23d. LOCATION<br>CITY OR TOWN STATE<br>Montgomery Penn. |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Robert A. Pumphrey Funeral Homes, P.A.  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 18 1981  |  |  |   |  |  |

Penn.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                             |   |  |  |   |  |                                       |   | REG. NO. 16462  |                                   |
|--|--|-----------------------------|---|--|--|---|--|---------------------------------------|---|---|-----------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>BROTHER George J. STRICKROTH</b>  |  |                             |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> <b>6-7-1981</b> |   |  |                                       |   | 2b. HOUR<br><b>A</b>  |                                   |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>CAUCASIAN</b> |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>NOV 17, 1917</b> |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>63</b> YRS.   |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. |   | 2c. DATE PRONOUNCED DEAD<br><b>June 7 1981 9:30 A</b>   |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  |                             | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                   |   |                                   |
| 10. CITY OR TOWN OF DEATH<br><b>Seneca</b>   |  |                             | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Reiley House</b> |  |  |   |  |                                       | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>TEACHER</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE<br><b>MARYLAND</b>  |  |                             | 13b. COUNTY<br><b>PRINCE GEORGES</b>  |  | 13c. CITY OR TOWN<br><b>BELTSVILLE</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                    |                                       | 13e. STREET ADDRESS<br><b>6011 AMMENDALE ROAD</b>                               |   |                                   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>PETER STRICKROTH</b>  |  |                             |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>BARBARA GECKLEIN</b>                 |   |  |                                       |   |   |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>NO</b>   |  |                             |   |  | 16b. SOCIAL SECURITY NO.<br><b>179-36-3475</b>   |   | 17. INFORMANT<br><b>BR. PATRICK F. POWERS, F.S.C. SAME AS 1</b>  |                                       |   |   |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ASphyxia -</b><br><b>95-31</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost:<br>(b) <b>Putting Plastic bag over head.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |                             |   |  |  |   |  |                                       |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                                   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>Alcoholism.</b>  |  |                             |   |  |  |   |  |                                       |   |   |                                   |
| 19a. DATE OF OPERATION   |  |                             |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |  |                                       |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                   |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                             |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>7 am. 6-7-1981</b>                 |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Put Plastic bag over head.</b> |                                       |   |   |                                   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>   |  |                             |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>Half Way House.</b>    |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>Reiley House. Seneca Montgomery Md</b>                     |                                       |   |   |                                   |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  |  |                             |   |  |  |   |  |                                       |   | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion |                                   |
| ACTUAL SIGNATURE<br><b>John S. Ball</b>  |  |                             |   |  | TITLE (SPECIFY)<br><b>Deputy</b>   |   |  |                                       |   | DATE SIGNED<br><b>June 7, 1981</b>  |                                   |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>JOHN G. BALL</b>  |  |                             |   |  | ADDRESS<br><b>BETHESDA, MARYLAND</b>   |   |  |                                       |   |   |                                   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  |                             |   |  | 23b. DATE<br><b>6/11/81</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CHRISTIAN BROTHERS</b>  |                                       |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>AMMENDALE MARYLAND</b>   |                                   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>FRANCIS J. COLLINS</b>  |  |                             |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 12 1981</b>                                      |   |  |                                       |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |                                   |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901  |  |                             |   |  |  |   |  |                                       |   |   |                                   |

BP

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |                          |   |  |   |                            |  |  |   |
|---|--|---|--------------------------|---|--|---|----------------------------|--|--|---|
| CERTIFICATE OF DEATH  |  |   |                          |   |  |   |                            |  |  |   |
| REG. NO.  |  |   |                          |   |  |   |                            |  |  |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   | FIRST MIDDLE LAST        |   |  | 2a. DATE OF DEATH   |                            | MONTH DAY YEAR   |  | 2b. HOUR  |
| Lena  |  |   | Stuckey                  |   |  | 6-7-81  |                            |  |  | 7:45p   |
| 3. SEX  |  | 4. RACE   |                          | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |                            | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS.                                |
| female  |  | caucasian   |                          | Dec. 10, 1906   |  | 74  |                            | MONTHS DAYS  |  | HOURS MIN.                                      |
| 7a. BIRTHPLACE (STATE OR FOREIGN)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |                          | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |                            |  |  |   |
| North Carolina  |  | USA   |                          |   |  | Montgomery MD.  |                            |  |  |   |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                          |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |                            | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |
| Silver Spring   |  | Holy Cross Hospital   |                          |   |  | Housewife   |                            | Home   |  |   |
| 13a. STATE  |  | 13b. COUNTY   |                          | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                            | 13e. STREET ADDRESS  |  |   |
| Maryland  |  | Montgomery  |                          | Kensington  |  | XX  |                            | 10225 Kensington Pkwy.   |  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |  |   |                          |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST      |   |                            |  |  |   |
| Luther Preston Valentine  |  |   |                          |   | Bettie Crawford                                    |   |                            |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |  |   | 16b. SOCIAL SECURITY NO. |   | 17. INFORMANT ADDRESS                              |   |                            |  |  |   |
| No  |  |   | 283 03 8734              |   | David Stuckey husband same as #13                  |   |                            |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |  |   |                          |   |  |   |                            |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiac arrest</u>   |  |   |                          |   |  |   |                            |  |  | 3 d   |
| 4029<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive Heart disease</u>  |  |   |                          |   |  |   |                            |  |  | years   |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |   |                          |   |  |   |                            |  |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a<br><u>pneumonitis, Diabetes mellitus, arteriosclerosis, vascular disease</u>   |  |   |                          |   |  |   |                            |  |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                          |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)  |  |   |                            |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE, FARM, ETC.)                                       |                          | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |                            |  |  |   |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>10/80</u> to <u>6/7/81</u> , that (I) (we) last saw the deceased alive on <u>6/7/81</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |   |                          |   |  |   |                            |  |  |   |
| 22b. SIGNATURE<br><u>Jeremy V. Cooke</u>  |  |   |                          |   | DEGREE<br><u>MD</u>                                |   |                            | 22c. DATE SIGNED<br><u>6/8/81</u>  |  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Jeremy V. Cooke</u>   |  |   |                          |   | 22e. ADDRESS<br><u>10400 Conn. Ave. Kensington</u> |   |                            |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE   |                          | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |                            |  |  |   |
| Burial  |  | 6-11-81   |                          | Alamance Memorial   |  | Park Alamance Co., N.C.   |                            |  |  |   |
| 24. FUNERAL DIRECTOR'S NAME<br><u>Pearson's Funeral Home</u>  |  |   |                          |   | 25a. DATE REC'D. BY REGISTRAR                      |   | 25b. REGISTRAR'S SIGNATURE |  |  |   |
| 472 N. Washington St., FC., Va.   |  |   |                          |   | JUN 12 1981  |   | <u>Jeffrey McHenry</u>     |  |  |   |

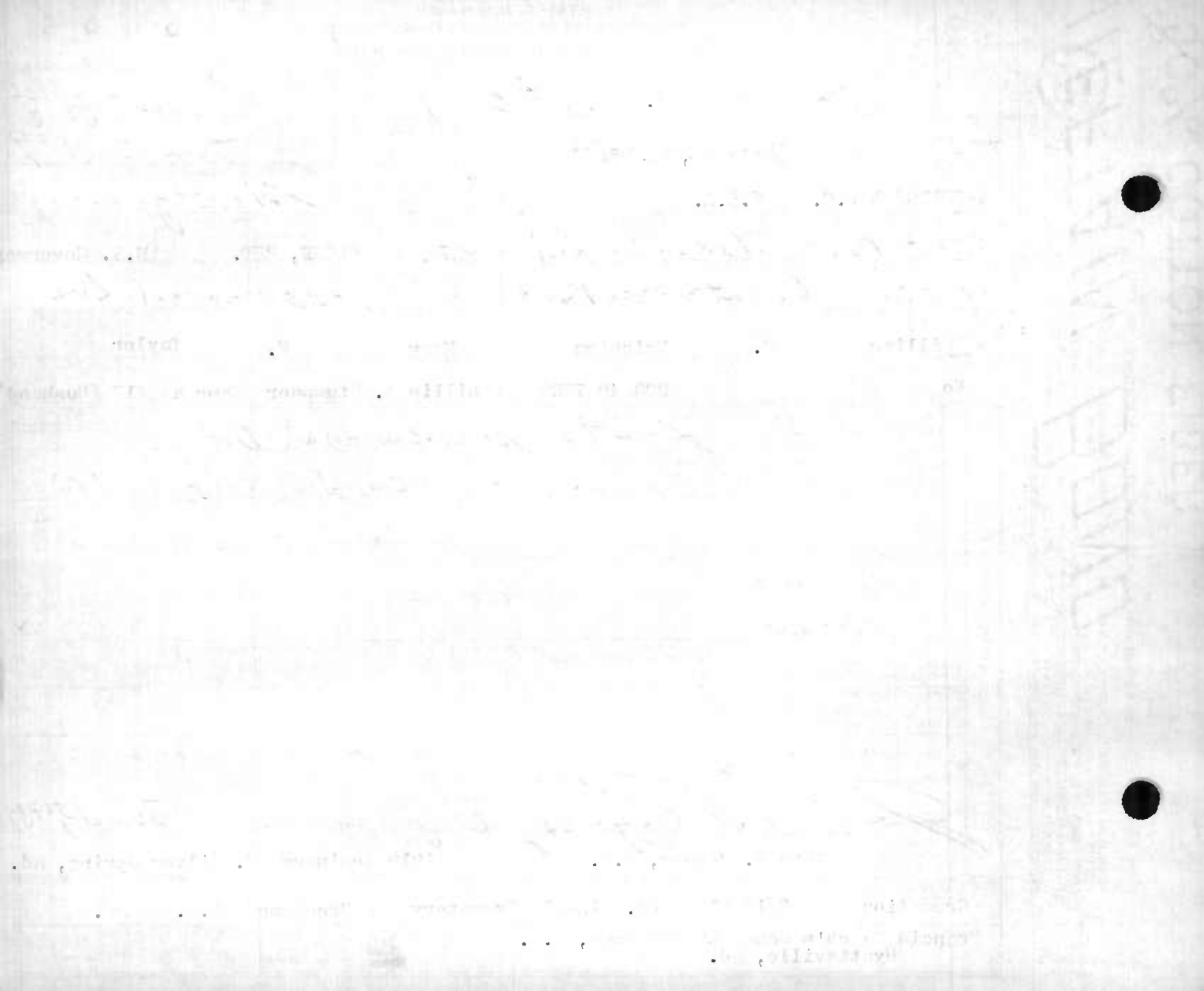


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

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(VR A15 ME (5))  
15M 2/80

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                      |  |  |  |   |  |  |   | REG. NO. 16464   |  |
|--|--|----------------------|--|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>STELLA K. STUMPNER</b>   |  |                      |  |  |  |   |  |  |   | 2a. DATE KNOWN OF DEATH <b>June 15, 1981</b>               |  |
| 3. SEX <b>FEMALE</b>   |  | 4. RACE <b>WHITE</b> |  | 5. DATE OF BIRTH <b>July 24, 1896</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>84 YRS.</b>                  |  | 7. DATE PRONOUNCED DEAD <b>June 15, 1981</b>   |   | 2b. HOUR <b>2:21 P.M.</b>                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WASHINGTON D.C.</b>   |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY MD.</b> |  |
| 10. CITY OR TOWN OF DEATH <b>TAKOMA PARK</b>   |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOW IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WASHINGTON ADVENTIST HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CLERK, RET.</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>   |  |
| 13a. STATE <b>MARYLAND</b>   |  |                      |  | 13b. CITY OR TOWN <b>PRINCE GEORGES HYATTSVILLE</b>  |  |   |  | 13d. INSIDE CITY LIMITS? <b>YES</b> NO <input type="checkbox"/>  |   | 14. STREET ADDRESS <b>3608 Hamilton Street</b>             |  |
| 14. FATHER'S NAME <b>William H. Krichton</b>   |  |                      |  | 15. MOTHER'S MAIDEN NAME <b>Mary E. Taylor</b>   |  |   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>   |  |                      |  | 16b. SOCIAL SECURITY NO. <b>220 48 7508</b>  |  |   |  | 17. INFORMANT <b>Phillip A. Stumpner Same as #13 (Husband)</b>   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1 DEATH WAS CAUSED BY:<br><b>4291</b> IMMEDIATE CAUSE (a) <b>Acute Myocardial Inf.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>Chronic Myocardial Inf.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Yrs</b> |  |                      |  |  |  |   |  |  |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a. <b>None</b>  |  |                      |  |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION <b>None</b>   |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                      |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |   |  | 21f. LOCATION CITY OR TOWN COUNTY STATE  |   |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>                     |  |                      |  |  |  |   |  |  |   |  |  |
| ACTUAL SIGNATURE <b>John S. Rogers, M.D.</b> TITLE (SPECIFY) <b>Medical Examiner</b>   |  |                      |  |  |  |   |  |  |   | DATE SIGNED <b>June 15, 1981</b>                           |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers, M.D.</b>  |  |                      |  | ADDRESS <b>1919 Seminary Rd. Silver Spring, Md.</b>  |  |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>   |  |                      |  | 23b. DATE <b>6/16/81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Crematory</b> |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood P.G. Md.</b> |  |  |
| 24. FUNERAL DIRECTOR NAME <b>Francis Gasch's Sons Funeral Home, P.A.</b> ADDRESS <b>Hyattsville, Md.</b>   |  |                      |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>JUN 17 1981</b>                |  | 25b. REGISTRAR'S SIGNATURE <b>Anthony McCreedy</b>   |   |  |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 8 1 1 6 4 6 5  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>DOROTHY G. SUDDUTH   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>JUNE 16 1981   |  |  |  |
| 3. SEX<br>Female   |  |   |  | 2b. HOUR<br>11:01 AM   |  |  |  |
| 4. RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>August 15 1911   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>69  |  | 7. IF UNDER 1 YEAR MONTHS DAYS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Washington, D.C.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD  |  |
| 10. CITY OR TOWN OF DEATH<br>Silver Spring   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Holy Cross Hospital |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Salesperson   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Dept. Store   |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Montgomery   |  | 13c. CITY OR TOWN<br>Gaithersburg  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Leroy   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Josephine Heirlich  |  | 13e. STREET ADDRESS<br>17060 King James Way  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>no  |  | 16b. SOCIAL SECURITY NO.<br>577-01-7292   |  | 17. INFORMANT ADDRESS<br>Rebecca Stake 4708 Bartram St., 20853 Rockville, Md.  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Metastatic ovarian carcinoma</u><br>1830<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>1830</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <u>1830</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Severe bronchitis &amp; emphysema</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>6 mos</u> |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                                  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>April 19 81</u> to <u>6/16 19 81</u> , that (I) (we) lost <u>above</u> , (I) (we) (did) not view the body after death.   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><u>B.N. ROSENBAUM, M.D.</u>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>     |  | 22c. DATE SIGNED<br>6/16/81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>B.N. ROSENBAUM  |  |   |  | 22e. ADDRESS<br>3720 FARRAGUT AVE<br>KENSINGTON, MD 20795  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>June 19, 1981  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arlington National Cem. Ft. Myer   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Virginia  |  |
| 24. FUNERAL DIRECTOR NAME<br>Robert A. Pumphrey  |  |   |  | 24. FUNERAL DIRECTOR ADDRESS<br>200 W. Montgomery Ave., Rockville, Md. 20850   |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 24 1981   |  |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Robert A. Pumphrey</u>  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

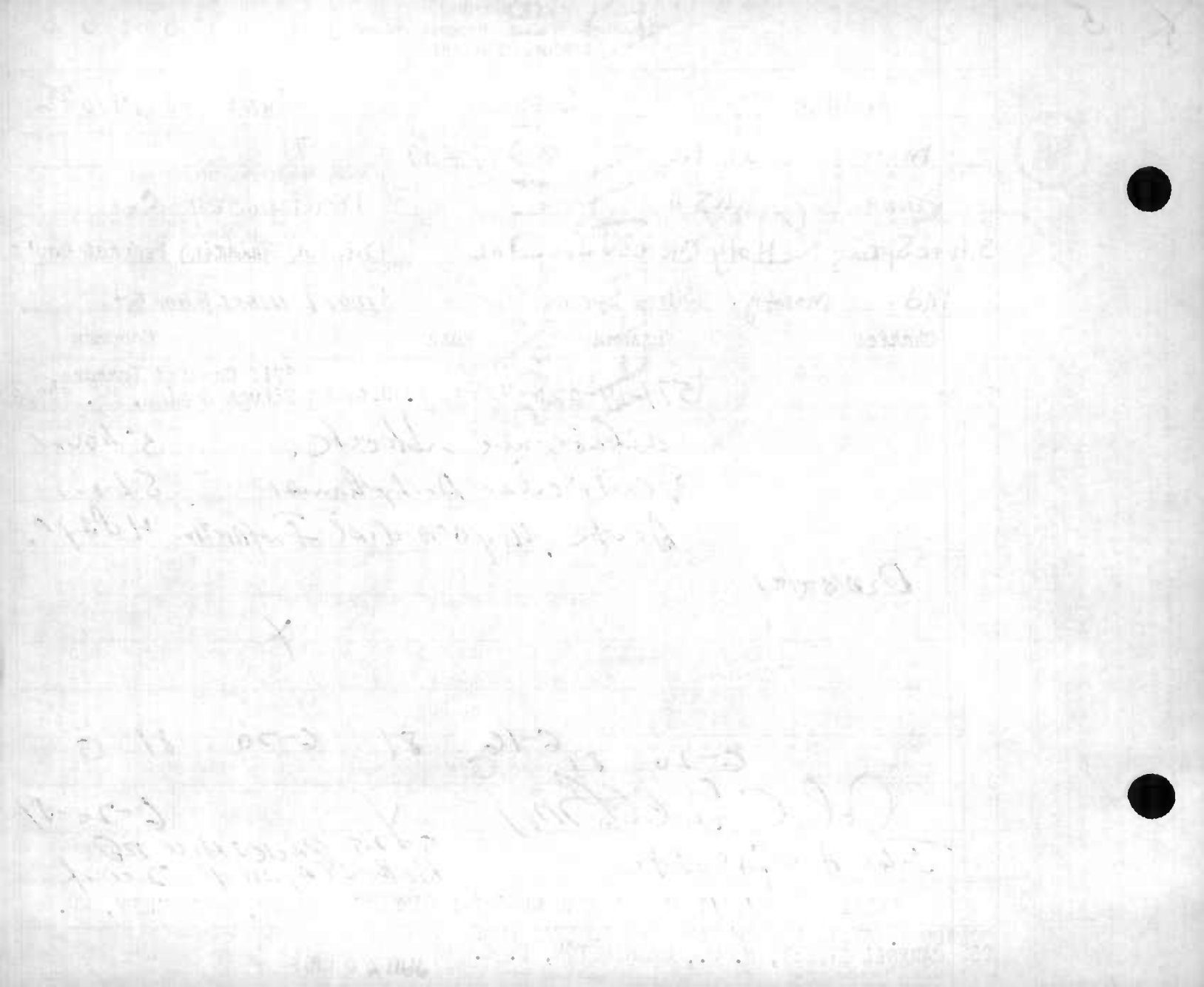
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REG. NO.

|  |   |   |  |   |   |  |
|--|---|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ARTHUR SUSSMAN</b>  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR <b>JUNE 20 1981</b>   |   | 2b. HOUR <b>10:55 AM</b>  |  |
| 3 SEX <b>MALE</b>  | 4 RACE <b>White</b>   | 5. DATE OF BIRTH MONTH DAY YEAR <b>8-19-09</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PENNA.</b>  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY Co. MD.</b>  |   |  |
| 10. CITY OR TOWN OF DEATH <b>Silver Spring</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b> |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Chief of Printing Federal Gov't</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>Md. Montg. Silver Spring</b>   | 13b. COUNTY   | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>         | 13e. STREET ADDRESS <b>10017 MARKHAM ST.</b>  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Sussman</b>   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rose Goodman</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>   |   |  |
| 16b. SOCIAL SECURITY NO. <b>579-14-0206</b>  |   | 17. INFORMANT ADDRESS <b>3718 Capulet Terrace, Silver Spring, Md. 20906</b>   |  |   |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiogenic Shock</b><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Ventricular Arrhythmias</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Acute Myocardial Infarction</b><br>4 days. |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 hours</b><br><b>5 hours</b><br><b>4 days</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:<br><b>Diabetes</b>  |   |   |  |   |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)          |  |   |   |  |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>6-16 81</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6-16 81</b> to <b>6-20 81</b> that (I) (we) last saw the deceased alive on <b>6-20 81</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.         |   |   |  |   |   |  |
| 22b. SIGNATURE <b>John A. Gacotta</b>  |   | DEGREE <b>MD</b>  |  | 22c. DATE SIGNED <b>6-20-81</b>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John A. Gacotta</b>   |   | 22e. ADDRESS <b>5725 Rockville Rd Bethesda, Md 20814</b>  |  | 22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |   | 23b. DATE <b>6/22/1981</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>JUDEAN MEMORIAL GARDENS</b>   |   |  |
| 23d. LOCATION <b>OLNEY, MONTGOMERY, MD.</b>  |   | 23e. DATE REC'D. BY REGISTRAR <b>JUN 20 1981</b>  |  | 23f. REGISTRAR'S SIGNATURE <b>[Signature]</b>   |   |  |

DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME  
232 CARROLL STREET, N. W., WASHINGTON, D. C.





Items 18b. Film #G556

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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FOR  
1. STATE REGISTRAR 6-29-81 al

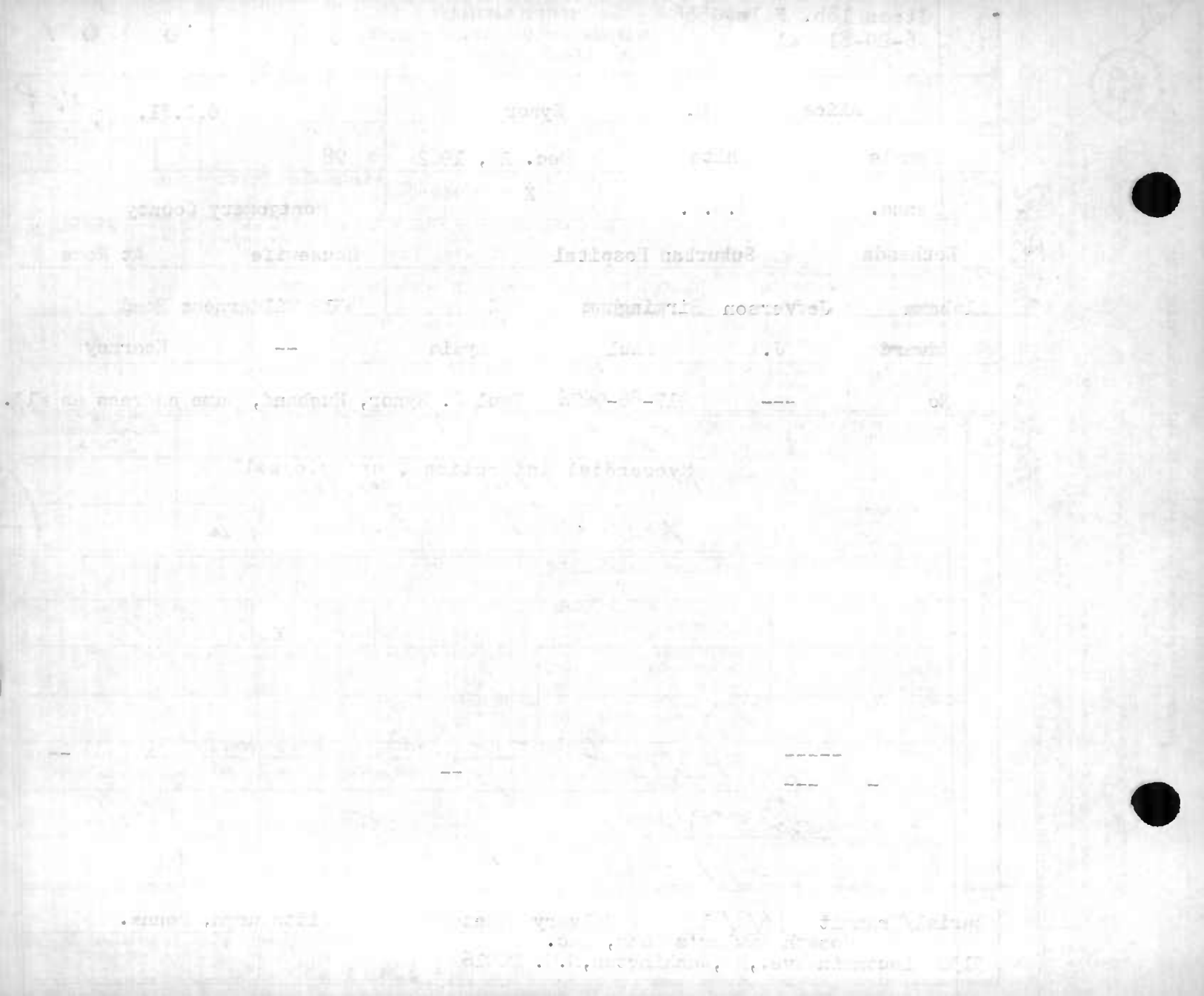
REG. NO.

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Alice H. Synor   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>6.3.81.                                |  | 2b. HOUR<br>8:26 P   |
| 3 SEX<br>Female   | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Dec. 29, 1902   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Penna.   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County MD.                        |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Suburban Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife | 12b. KIND OF BUSINESS OR INDUSTRY<br>At Home   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Alabama  |  |   | 13b. COUNTY<br>Jefferson  | 13c. CITY OR TOWN<br>Birmingham  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Edward J. Paul  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lydia Kearney                |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>417-86-9676   |   | 17. INFORMANT<br>ADDRESS<br>Paul J. Synor, Husband, Same address as #13.             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest</u><br><u>4100</u><br>DUE TO, OR AS A CONSEQUENCE OF, (b) <u>Myocardial infarction, anterior wall</u><br><u>massive infarct, suspected</u><br>DUE TO, OR AS A CONSEQUENCE OF, (c) <u>Arteriosclerosis + Hypertensive CVDs</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>3 hrs.</u> |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) ( <del>the physician</del> ) attended the deceased from <u>6:30 AM 6/3 1981</u> to <u>8:30 PM 6/3 1981</u> , that (I) ( <del>my</del> ) last saw the deceased alive on <u>6:30 AM 6/3 1981</u> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>do not</del> ) view the body after death.              |  |   |   |  |  |
| 22b. SIGNATURE<br><u>Kirk E. Flanagan</u>   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |   | 22c. DATE SIGNED<br><u>6/3/81</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>KIRK E FLANAGAN M.D.</u>  |  | 22e. ADDRESS<br><u>9810 Old Georgetown Rd ! 20014</u>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial/Transit   |  | 23b. DATE<br>6/8/81   | 23c. NAME OF CEMETERY OR CREMATORY<br>Calvary Cemetery                        |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Pittsburgh, Penna. WY STATE  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Joseph Gawler's Sons, Inc.<br>5130 Wisconsin Ave., NW, Washington, D.C. 20016   |  |   | 25a. DATE REC'D. BY REGISTRAR<br>JUN 10 1981                                  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Jeffrey McCreedy</u>  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other trauma involving the medical examiner must be notified at 707-7000.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                         |  |   |  |  |  |   |  | REG. NO. 16468  |  |   |  |
|--|--|-------------------------|--|---|--|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Lewis Hamilton Tabler, Sr.</b>  |  |                         |  |   |  |  |  |   |  | 2a. DATE OF DEATH KNOWN OR ESTIMATED MONTH DAY YEAR<br><b>6/2 19 81</b> |  | 2b. HOUR<br><b>11:15 A.</b>   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b> |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Nov. 10, 1929</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br><b>51 YRS.</b> |  | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR<br><b>6/2 19 81</b>   |  | 7d. HOUR<br><b>11:15 A.</b>   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County</b> MD.              |  |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>  |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>4207 Weller Road</b>  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Montgomery County</b>   |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>Maryland</b>  |  |                         |  | 13b. CITY OR TOWN<br><b>Montgomery</b>  |  |  |  | 13c. CITY OR TOWN<br><b>Silver Spring</b>   |  |   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Lewis F. Tabler</b>  |  |                         |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Ethel V. Hessie</b>  |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br><b>yes</b>  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>214 28 9187</b>                                    |  |
| 17. INFORMANT ADDRESS<br><b>Jacqueline A. Tabler same as 13c</b>   |  |                         |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute myocardial disease.</b><br>4291<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>None</b> |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>None</b>  |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                         |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>None</b>  |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                         |  |   |  |  |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <i>John S. Rogers</i> M.D.  |  |                         |  |   |  |  |  |   |  | TITLE (SPECIFY)<br><b>Deputy</b>  |  | DATE SIGNED<br><b>6/2/81</b>  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>John S. Rogers, M.D.</b>   |  |                         |  |   |  |  |  |   |  | ADDRESS<br><b>1919 Seminary Road Silver Spring, Montgomery, Md.</b>     |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |                         |  | 23b. DATE<br><b>6/5/81</b>  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parklawn Memorial Park</b>   |  |   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Rockville, Maryland</b>             |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Tyson Wheeler Funeral Home, Inc.</b>   |  |                         |  |   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 9 1981</b>                      |  | 25b. REGISTRAR'S SIGNATURE<br><i>John S. Rogers</i>                               |  |

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Table 2

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16/2/91

Patience Memorial Park, Nashville, Tennessee

2331 Rockville Pike, Rockville, Maryland  
Tyson Wheeler Tunnel Home, Inc.

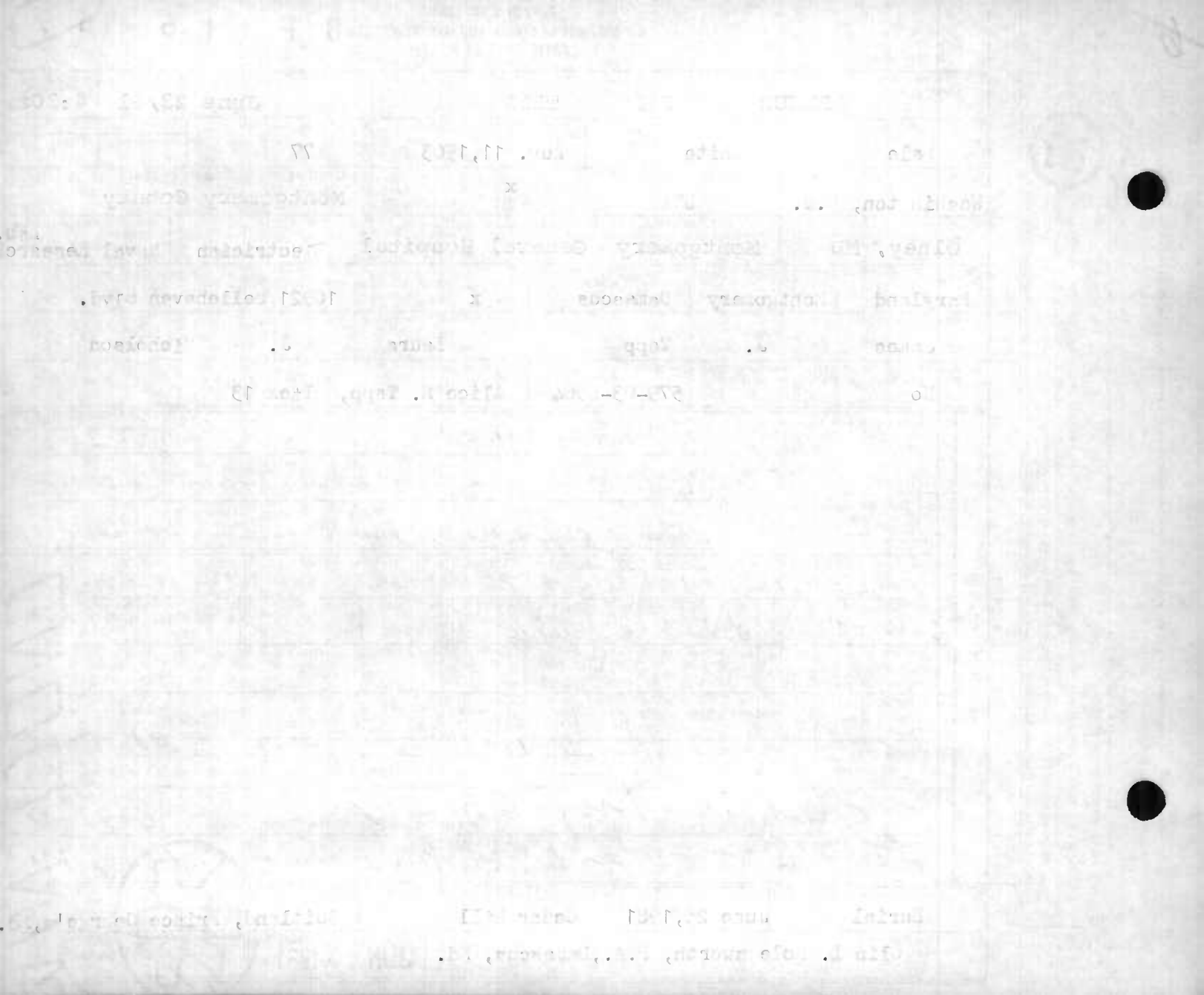
Tyson Wheeler Funeral Home, Inc.

## CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |   |  |  |   |  |
|--|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ARTHUR RAY TAPP</b>  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>June 23/81</b>                               |   | 2b. HOUR<br><b>4:30a</b>   |
| 3 SEX<br><b>Male</b>   | 4 RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Aug. 11, 1903</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b>   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Washington, D.C.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County</b> MD                             |  |
| 10. CITY OR TOWN OF DEATH<br><b>Olney, MD</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Montgomery General Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Electrician</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Naval Research</b> Lab.                                 |  |
| 13a. STATE<br><b>Maryland</b>  |   | 13b. COUNTY<br><b>Montgomery</b>   | 13c. CITY OR TOWN<br><b>Damascus</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>10921 Bellehaven Blvd.</b>   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James J. Tapp</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Laura J. Nicholson</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>579-03-8964</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Alice M. Tapp, Item 13</b>                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PULMONARY FAILURE</b>   |   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>24 HS</b>  |
| 1579<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>ADVANCED SEVERE RIGHT LUNG PNEUMONITIS</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>ADVANCED CARCINOMA OF PANCREAS</b>   |   |  |  |   | <b>8 DAYS</b><br><br><b>AT LEAST 1 YEAR</b>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>DIABETES MELLITUS &amp; SEVERE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE.</b>  |   |  |  |   |  |
| 19a. DATE OF OPERATION<br><b>6-10-81</b>   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Obstructive jaundice</b>  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6-20-81</b> , 19 <b>81</b> , to <b>6-22</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>6-22-81</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |  |  |   |  |
| 22b. SIGNATURE<br><b>Mano H. Diaz M.D.</b>   |   | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>6-23-81</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MANO H. DIAZ M.D.</b>  |   | 22e. ADDRESS<br><b>18111 Prince Philip Dr. Olney Md.</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |   | 23b. DATE<br><b>June 25, 1981</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill</b>   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Suitland, Prince George's, Md.</b>  |   | 24. FUNERAL DIRECTOR<br>NAME<br><b>Olin L. Mole sworth, P.A., Damascus, Md.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 25 1981</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |   |  |  |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |   |   | 8 1 1 6 4 7 0   |  |
|--|--|--|---|---|---|--|
| FOR<br>STATE<br>REGISTRAR  |  |  |   |   | REG. NO.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | FIRST   | MIDDLE  | LAST  | 2a. DATE OF DEATH  |
| EVELYN L. TEMES  |  |  |   |   |   | MONTH DAY YEAR   |
| 3. SEX   |  |  | 4. RACE   | 5. DATE OF BIRTH  |   | 6. AGE (IN YEARS LAST BIRTHDAY)                                |
| FEMALE   |  |  | CAUCASIAN   | AUG. 24 10  |   | 70 YRS.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |  | 7b. CITIZEN OF WHAT COUNTRY?  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |
| WASHINGTON, D.C.   |  |  | U.S.A.  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |
| SILVER SPRING  |  |  | 9737 MT. PISGAH RD  |   | HOUSEWIFE   |  |
| 13a. STATE   |  |  | 13b. COUNTY   | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS  |
| MD   |  |  | MONTGOMERY  | SILVER SPRING   | YES <input type="checkbox"/> NO <input type="checkbox"/>  | 9737 MT. PISGAH RD   |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |  |
| HERBERT F. KING  |  |  | WILLA RAY   |   | 16b. SOCIAL SECURITY NO.  |  |
|  |  |  |   |   | 577-62-0265   |  |
| 17. INFORMANT  |  |  | ADDRESS   |   | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Metastatic cancer to Liver</u><br><u>1749</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>Infiltrating duct carcinoma, Left breast</u><br>(c) <u></u><br>DUE TO, OR AS A CONSEQUENCE OF |  |
| DENNIS F. HUGHES   |  |  | SAME AS 13e   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>6 months</u>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>   |  |  |   |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|  |  |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |   |  |
|  |  |  |   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/28</u> 19 <u>81</u> , to <u>6/19 6/25</u> 19 <u>81</u> , that (I) (we) lost<br>saw the deceased alive on <u>6/25 6/19</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |   |   |   |  |
| 22b. SIGNATURE<br><u>Hubert J. Alpert</u>  |  | DEGREE<br><u>MD</u>  |   | 22c. DATE SIGNED<br><u>6/26/81</u>  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |   |   |   |  |
| HUBERT J. ALPERT   |  | 8630 FENTON ST., SILVER SPRING, MD                                     |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                     |
| BURIAL   |  | 6-29-81  |   | CEDAR HILL CEM.   |   | SUITLAND P.G. MD.  |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE  |   |  |
| FRANCIS J. COLLINS   |  | JUN 30 1981  |   | <u>Francis J. Collins</u>   |   |  |

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JUNE 22 11

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WASHINGTON, D.C.  
JUNE 22 1962

MEMORANDUM

TO :

FROM : DIRECTOR, FBI

SUBJECT: [Illegible]

NO

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RE: [Illegible]

NO

[Illegible]

[Illegible]

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WASHINGTON, D.C.

JUNE 22 1962

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[Illegible signature]

200 UNIVERSITY STREET, NEW YORK, N.Y. 10007

EXHIBIT 1, COLLINS, SILVER ST. 11, NO.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |  |  |  |  |   |
|---|--|---|--|---|--|--|--|--|---|
| 1 - FOR STATE REGISTRAR   |  |   |  |   | 8 1 1 6 4 7 1  |  |  |  |   |
| CERTIFICATE OF DEATH  |  |   |  |   | REG. NO.   |  |  |  |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARY TERR</b>  |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>6/4/81</b>  |  |  | 2b. HOUR<br><b>3:30 AM</b>   |   |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>AUG. 26, 1896</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b> YRS                                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>RUSSIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.                        |  |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>ROCKVILLE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>HEBREW HOME OF GREATER WASHINGTON</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>-----   |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |   |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>MONTGOMERY</b>  |  | 13c. CITY OR TOWN<br><b>GAITHERSBURG</b>  |  | 13e. STREET ADDRESS<br><b>9429 BETHANY PLACE</b>                                     |  |  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>  |  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>188-16-3706</b>  |  | 17. INFORMANT (DAUGHTER)<br><b>CLARA T. YABLON</b>  |  | ADDRESS <b>9429 Bethany Place Gaithersburg, MD. 20760</b>                            |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Septicemia</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Severe D. Mellitus</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chyloperglycemia, nonketotic state</b>  |  |   |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2500</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).   |  |   |  |   |  |  |  |  |   |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>      |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |   |
| 22a. I certify that (this hospital) attended the deceased from <b>APR 12nd 1981</b> to <b>6/4/81</b> , that (I) (we) last saw the deceased alive on <b>6/4/81</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |  |   |
| 22b. SIGNATURE<br><b>H-D. KHANEY</b>  |  |   |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  | 22c. DATE SIGNED<br><b>6/4/81</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MRS. D. KHANEY</b>  |  |   |  |   | 22e. ADDRESS<br><b>Hebrew Home 6121 Montrose Rd Rockville MD</b>   |  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>JUNE 5, 1981</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>KING DAVID MEM. GAR.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>FALLS CHURCH VA.</b>                |  |  |   |
| 24. FUNERAL DIRECTOR<br>NAME <b>DANZANSKY-GOLDBERG CHAPELS 1170 ROCKVILLE PIKE</b>  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR <b>JUN 9 1981</b>  |  |  |  |   |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                             |  |  |  |                                |   |  |   |  | REG. NO. 16472                               |  |
|---|-----------------------------|--|--|--|--------------------------------|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARY E. TESTU</b>  |                             |  |  |  |                                | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> <b>6 17 1981</b> |  | 2b. HOUR <b>11 AM</b>   |  |  |  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>Caucasian</b> | 5. DATE OF BIRTH<br>MONTH <b>August</b> YEAR <b>1895</b>   | 6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS. | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.   | IF UNDER 24 HRS.<br>HOURS MIN. | 7c. DATE PRONOUNCED DEAD <b>June 17, 1981</b>   |  | 7d. HOUR <b>11 AM</b>   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |                             | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rockville</b>   |                             | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>259 Congressional Lane #502</b> |  |  |                                | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>                               |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>                                      |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |                             | 13b. COUNTY<br><b>Montgomery</b>   |  | 13c. CITY OR TOWN<br><b>Rockville</b>  |                                | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                    |  | 13e. STREET ADDRESS<br><b>259 Congressional Lane #502</b>                             |  |  |  |
| 14. FATHER'S NAME<br>FIRST <b>James</b> MIDDLE <b>M.</b> LAST <b>O'Rourke</b>   |                             |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Amanda</b> MIDDLE <b>Caroline</b> LAST <b>Turner</b>  |                                |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br><b>No</b>   |                             | 16b. SOCIAL SECURITY NO.<br><b>216-40-7568</b>   |  | 17. INFORMANT<br><b>Alice O'Rourke</b>   |                                |   |  | 17b. ADDRESS<br><b>Same as 13</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Malnutrition - Sepsis - Pressure Sores</b><br>7/69<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) <b>Arthritis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Carcinomatosis - Carcinoma of Breast</b>   |                             |  |  |  |                                |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |                             |  |  |  |                                |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |                             |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                                |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |                                |   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |                             | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                                |   |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                             |  |  |  |                                |   |  |   |  |  |  |
| ACTUAL SIGNATURE <b>John G. Ball</b>  |                             |  |  | TITLE (SPECIFY) <b>Deputy</b> M.D. <b>Deputy</b>   |                                |   |  | DATE SIGNED <b>June 17 1981</b>   |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>John G. Ball</b>   |                             |  |  | ADDRESS <b>7936 Old Georgetown Rd, Bethesda, Maryland</b>  |                                |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |                             | 23b. DATE<br><b>June 19, 1981</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Forest Oak Cemetery</b>   |                                |   |  | 23d. LOCATION<br>CITY OR TOWN <b>Gaithersburg Montg.</b> COUNTY <b>Maryland</b> STATE |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Robert A. Pumphrey</b><br><b>Homes, P.A.</b> <b>Rockville, Maryland</b>   |                             |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 24 1981</b>  |                                | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |   |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

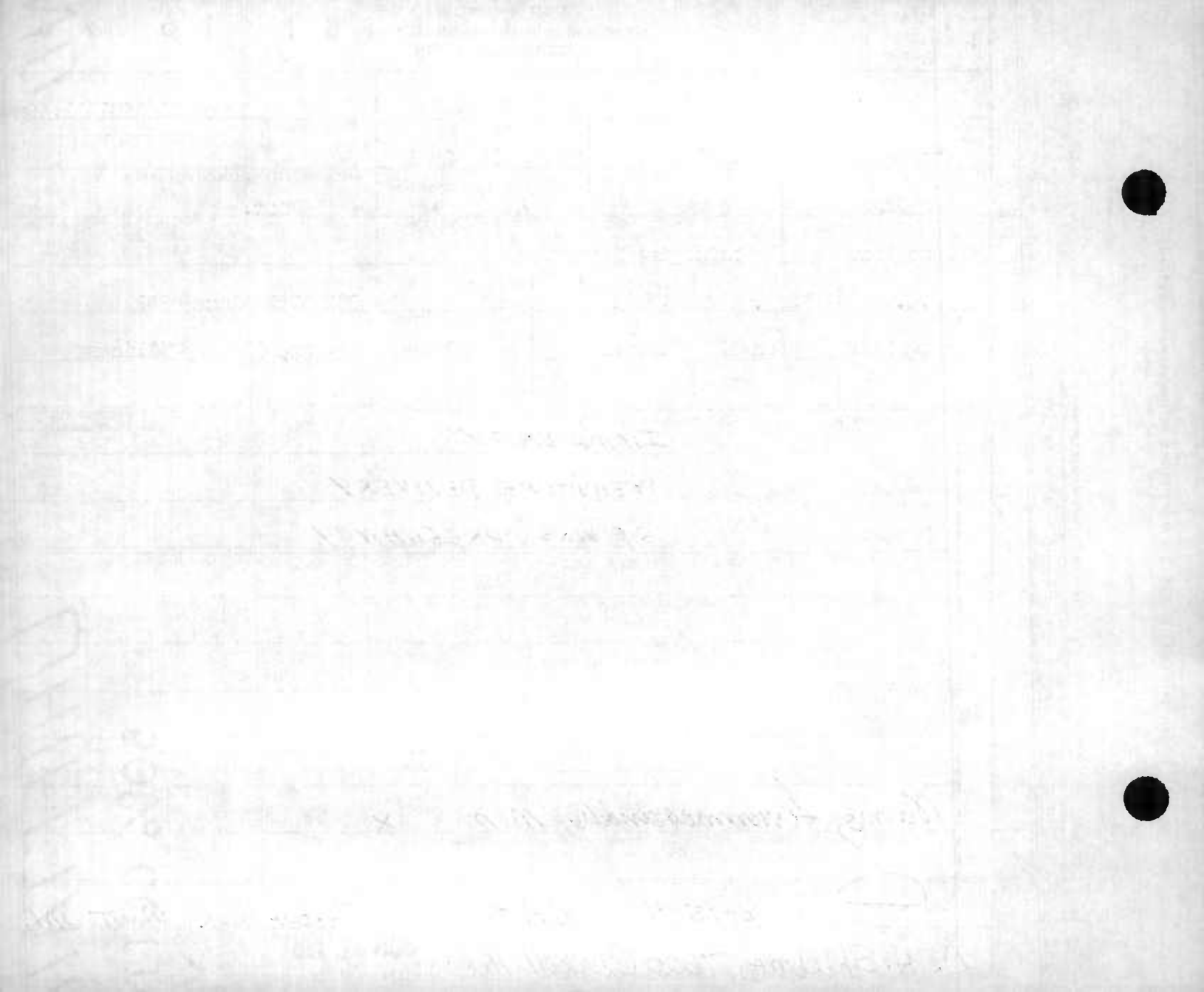
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |  |   |  |   |   |  |  |
|---|--|---|--|--|---|--|---|---|--|--|
| CERTIFICATE OF DEATH  |  |   |  |  |   |  |   |   |  |  |
| REG. NO. 8 1 1 6 4 7 3  |  |   |  |  |   |  |   |   |  |  |
| 1. FOR STATE REGISTRAR  |  |   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR   |  |   |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Thomas   |  |   |  |  | June 11 1981 11:49am  |  |   |   |  |  |
| 3. SEX male   |  | 4. RACE black   |  | 5. DATE OF BIRTH MONTH DAY YEAR June 11 1981   |   | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS               |   | IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY? yes  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH Mont. MD.                 |   |   |  |  |
| 10. CITY OR TOWN OF DEATH Takoma Park   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |   | 12b. KIND OF BUSINESS OR INDUSTRY                       |  |  |
| 13a. STATE D.C.   |  |   |  |  | 13b. COUNTY Wash.   |  | 13c. CITY OR TOWN Wash.   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Franklin Wendell Thomas   |  |   |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sylvia Darcel Williams   |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS  |   |  |   |   |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) IMMATURITY<br>7651 } DUE TO, OR AS A CONSEQUENCE OF (b) PREMATURE DELIVERY.<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) 20 WKS. PREGNANCY.<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |  |   |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |  |   |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |   |  |   |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |  |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) lost saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |   |  |   |   |  |  |
| 22b. SIGNATURE Barry Swormasandke, M.D.   |  |   |  |  | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   | 22c. DATE SIGNED  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  |  | 22e. ADDRESS  |  |   |   |  |  |
| 23a. BURIAL (CREMATION) REMOVAL (SPECIFY)   |  | 23b. DATE 6-15-81   |  | 23c. NAME OF CEMETERY OR CREMATORY WASH  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE Takoma Park, Mont. Md. |   |   |  |  |
| 24. FUNERAL DIRECTOR NAME Dr. H. Shirdma, 7600 Carroll Ave.   |  |   |  |  | 25a. RECEIVED BY REGISTRAR JUN 30 1981  |  | 25b. SIGNATURE  |   |  |  |

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the funeral director.

with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 1 1 6 4 7 4   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Ann Colman Thompson</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>6/12/81</b>  |  | 2b. HOUR<br><b>12:40 P.M.</b>  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Caucasian</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>April 25, 1893</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>88</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County MD.</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rockville</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Potomac Valley Nursing Home</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Nurse</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Private Duty</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  | 13a. STREET ADDRESS   |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Montgomery</b>   |  | 13c. CITY OR TOWN<br><b>Silver Spring</b>   |  | 13d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Frederick Colman</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Emma Cypher</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>215-20-3481</b>   |  | 17. INFORMANT ADDRESS<br><b>Roberta Ann Moldenhauer, Same as #13</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br><b>5789 GI bleeding, CHF, asthma</b><br>IMMEDIATE CAUSE (a) _____<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/16</b> 19 <b>77</b> to <b>6/12</b> 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>5/29</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.              |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Frauke Westphal M.D.</b>   |  |  |  | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>6/12/81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Frauke Westphal, M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>309 Veirs Mill Road Rockville, MD</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>June 16, 1981</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>South Dover Rural Cemetery</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Wingdale, New York</b>   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 18 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>L. J. McBrady</b>   |  |



10

## CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |  |   |  |  |   |  |   |  |
|--|--|--|---|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>WILLIAM MICHAEL THOMPSON, Jr.       |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>May 15, 1981 |  |  | 2b. HOUR<br>9:30 PM   |  |   |  |
| 3 SEX<br>Male  |  | 4 RACE<br>Black  |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>May 15, 1981  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br>1 15                  |  | 7b. HOUR<br>1 15                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD                        |  |   |  |
| 10 CITY OR TOWN OF DEATH<br>Olney  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Montgomery General Hospital |   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Newborn |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>None |  |
| 13a. STATE<br>Maryland   |  | 13b. CITY OR TOWN<br>Montg.  |   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13d. STREET ADDRESS<br>7901 Spiceberry Ln. Apt. 1                           |  |   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Michael Thompson          |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Oleo Mae Williams   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>No  |   | 17 INFORMANT<br>ADDRESS  |  |   |  |   |  |

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  
PART 1 DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Severe prematurity - 20/21 weeks

7650  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF  
(b) Respiratory Distress

DUE TO, OR AS A CONSEQUENCE OF  
(c) Cardiorespiratory Arrest

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Premature male infant

MEDICAL CERTIFICATION

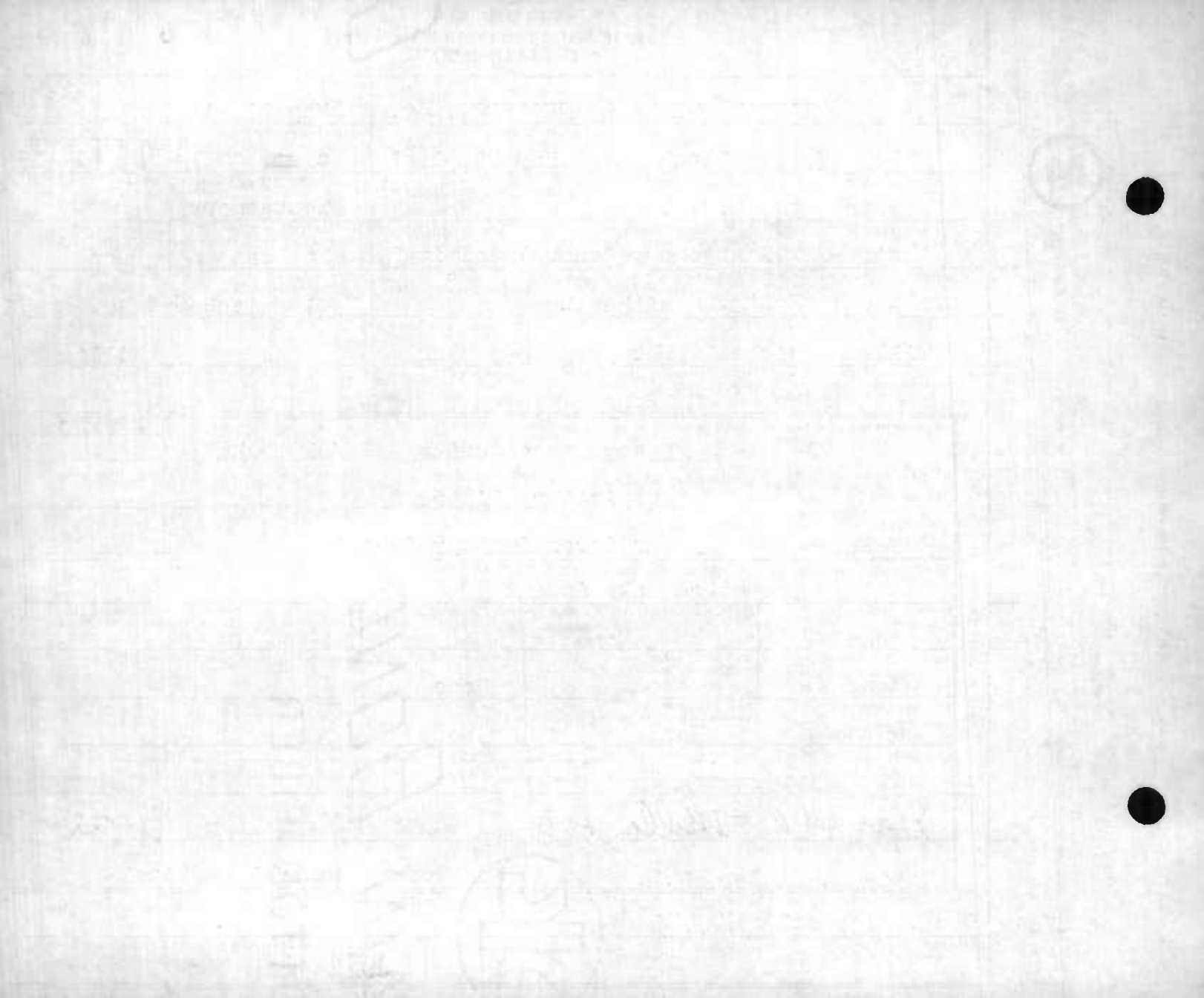
|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION<br>None   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>None                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>              |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING CAUSE OF DEATH<br>(IF EITHER, GIVE MEDICAL EXAMINER)<br>None  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>None 19                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br>None |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>None  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>None |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>None                              |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-15 19 81, to 19 81, that (I) (we) last saw the deceased alive on 5-15 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>David R. Miller, M.D.  |  |  |  | DEGREE<br>M.D.   |  | 22c. DATE SIGNED<br>6/22/81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>David R. Miller, M.D.   |  |  |  | 22e. ADDRESS<br>Montgomery General Hospital  |  |  |  |

|   |  |                      |  |  |  |  |  |
|---|--|----------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Hosp. disposal |  | 23b. DATE<br>5/15/81 |  | 23c. NAME OF CEMETERY OR CREMATORY           |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |  |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS                         |  |                      |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 24 1981 |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

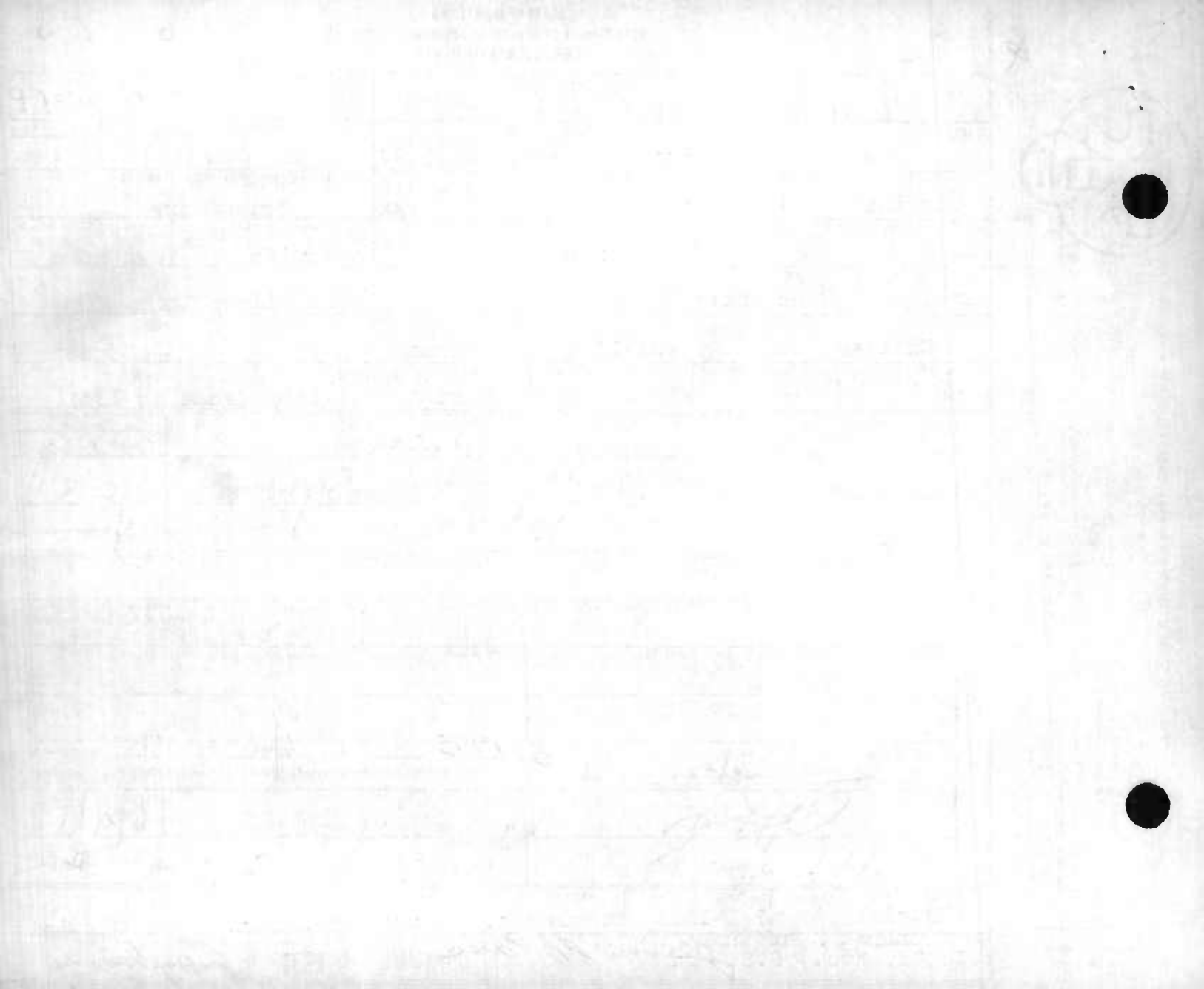
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 3 days of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |   |  |  |  |  |  |   |
|---|--|---|---|--|--|--|--|--|---|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>Oueda Mark Thwaite</b>  |  |   | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>6 27 81</b>                  |  |  | 2b HOUR<br><b>4:50 P</b>   |  |  |   |
| 3 SEX<br><b>Female</b>  |  | 4 RACE<br><b>White</b>  |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Aug. 4, 1894</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b> YRS  |  | 7 IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |   |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.   |  |  |   |
| 10 CITY OR TOWN OF DEATH<br><b>Olney</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sharon Nursing Home</b> |   |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>  |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>own home</b>  |   |
| 13a STATE<br><b>Maryland</b>  |  | 13b COUNTY<br><b>Montgomery</b>   |   | 13c CITY OR TOWN<br><b>Bethesda</b>  |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e STREET ADDRESS<br><b>5700 Wilson Lane,</b>   |   |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William C. Phillips</b>   |  |   |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna Borden</b>   |  |  |  |  |   |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>no</b>   |  |   |   | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>578-24-0365</b>   |  | 17 INFORMANT (nephew) ADDRESS<br><b>Robert A. Phillips-(same as 13e)</b>   |  |  |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b><br><b>4029</b> DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Oxygen Brain Syndrome</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>PTSD</b> |  |   |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 1/2 years</b><br><b>years</b><br><b>year</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |  |  |  |  |  |   |
| 19a DATE OF OPERATION   |  |   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19            |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |   |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |   |
| 22a I certify that (I) (this hospital) attended the deceased from <b>5/5/1975</b> to <b>6/28/81</b> , that (I) (we) lost saw the deceased alive on <b>6/28/81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.  |  |   |   |  |  |  |  |  |   |
| 22b SIGNATURE<br><b>Chad L. ...</b>   |  |   | DEGREE<br><b>MD</b>   |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c DATE SIGNED<br><b>6/28/81</b>  |   |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Chad L. ...</b>  |  |   | 22e ADDRESS<br><b>1811 R. ...</b>                                     |  |  |  |  |  |   |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |   | 23b DATE<br><b>7-1-1981</b>   |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Tomsbrook Cemetery</b> |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Tomsbrook Virginia</b> |  |   |
| 24 FUNERAL HOME<br><b>Warner E. Pumphrey, Inc.</b>  |  |   | 25a DATE REC'D BY REGISTRAR<br><b>JUL 6 1981</b>                      |  |  | 25b REGISTRAR'S SIGNATURE<br><b>P. ...</b>   |  |  |   |





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS ANTICIPATED, PLEASE EXECUTE THE CERTIFICATE, WRITING "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME(5))  
15M 7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |                  |                |   |  |  |   |  |  |  |  |   |                                |  |            |   |  |   |                         |                                       |            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|--|--|------------------|----------------|---|--|--|---|--|--|--|--|---|--------------------------------|--|------------|---|--|---|-------------------------|---------------------------------------|------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |                  | FIRST<br>Yeram |   |  | MIDDLE<br>S.   |   |  | LAST<br>Touloukian                       |  |  | 2a. DATE KNOWN<br>OF DEATH  |                                |  | MONTH<br>6 |   |  | DAY<br>12   |                         |                                       | YEAR<br>81 |  |  | 7b. HOUR<br>4:44<br>P M                    |  |  |  |  |  |  |  |  |  |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>CAUC. |                | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12-28-20  |  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>60 YRS. |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN. |  | IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN. |   | 7c. DATE<br>PRONOUNCED<br>DEAD |  |            | MONTH DAY YEAR<br>6.12.81   |  |   | 2d. HOUR<br>4:44<br>P M |                                       |            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Turkey  |  |                  |                | 7b. CITIZEN OF WHAT COUNTRY?<br>United States   |  |  |   | 8. MARRIED<br>WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD   |                                |  |            |   |  |   |                         |                                       |            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1b. CITY OR TOWN OF DEATH<br>Bethesda  |  |                  |                | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Suburban Hospital |  |  |   |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Professor                            |                                |  |            | 12b. KIND OF BUSINESS OR INDUSTRY<br>Education  |  |   |                         |                                       |            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 13a. STATE<br>INDIANA  |  |                  |                |   |  |  |   |  |  |  |  | 13b. CITY OR TOWN<br>Tippecanoe   |                                |  |            | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |                         | 13d. STREET ADDRESS<br>233 PAWNEE DR. |            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Sarkis Touloukian  |  |                  |                |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Zaruhi Ferhadian          |   |  |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No                           |                                |  |            |   |  | 16b. SOCIAL SECURITY NO.<br>577-46-4013   |                         |                                       |            |  |  | 17. INFORMANT (wife)<br>Arsilya Touloukian |  |  |  |  |  | ADDRESS<br>233 Pawnee Drive W. Lafayette, Ind            |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION<br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) CORONARY ARTERIO SCLEROSIS<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>ACUTE<br>18 YRS         |  |                  |                |   |  |  |   |  |  |  |  |   |                                |  |            |   |  | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |                         |                                       |            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |                  |                |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                          |   |  |  |  |  |   |                                |  |            |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                         |                                       |            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                  |                |   |  | 21b. TIME OF INJURY<br>HOUR MONTH DAY YEAR<br>9:25 P.M. 6 12 1981          |   |  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>COLLAPSED AT MEETING |                                |  |            |   |  |   |                         |                                       |            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |                  |                |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>HOLIDAY INN |   |  |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>8120 Wisconsin Ave Bethesda MONT MD              |                                |  |            |   |  |   |                         |                                       |            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .<br>Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion |  |                  |                |   |  |  |   |  |  |  |  |   |                                |  |            |   |  | 22b. SIGNATURE<br>Francis C. Mayle  |                         |                                       |            |  |  | 22c. TITLE (SPECIFY)<br>M.D. Dept          |  |  |  |  |  | 22d. MEDICAL EXAMINER<br>DATE SIGNED<br>6/12/81<br>20014 |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |                  |                |   |  | 23b. DATE<br>June 16, 1981   |   |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Spring Vale Cemetery  |                                |  |            |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>West Lafayette, Indiana   |                         |                                       |            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Robert A. Bumphrey Funeral Homes, P.A. Bethesda, Maryland  |  |                  |                |   |  |  |   |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 13 1981  |                                |  |            |   |  | 25b. REGISTRAR'S SIGNATURE<br>L. J. Kelly   |                         |                                       |            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |



1. Name of the plant or material  
2. Date of collection  
3. Locality  
4. Collector's name  
5. Number of specimens  
6. Description of the specimen  
7. Remarks

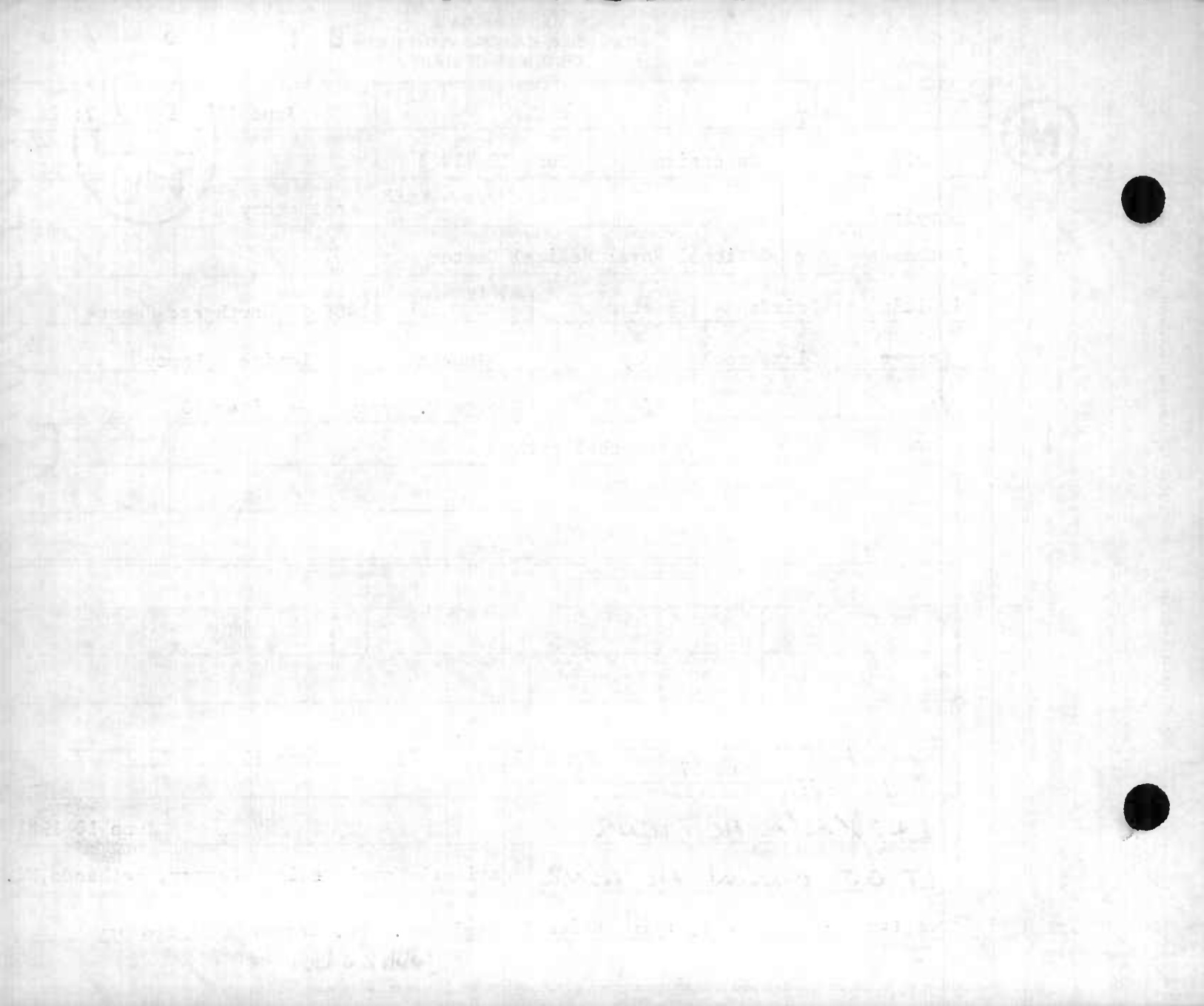
8. Name of the collector  
9. Date of collection  
10. Locality  
11. Collector's name  
12. Number of specimens  
13. Description of the specimen  
14. Remarks

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |  |  |  |   |   |   |  |
|---|--|---|--|--|--|--|---|---|---|--|
| CERTIFICATE OF DEATH  |  |   |  |  |  |  |   |   |   |  |
| 1. FOR STATE REGISTRAR  |  |   |  |  | REG. NO.   |  |   |   |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Baby Girl TRACY   |  |   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>June 17 1981   |  |   | 2b. HOUR<br>7:42A M                                 |   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Caucasian  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>June 17 1981  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS MONTHS DAYS<br>1 28           |   | 7. IF UNDER 1 YEAR<br>IF UNDER 24 HRS<br>HOURS MIN. |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.               |   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (GIVE IN SUCH FACILITY, GIVE STREET ADDRESS)<br>National Naval Medical Center |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>N/A |   | 12b. KIND OF BUSINESS OR INDUSTRY                   |   |  |
| 13a. STATE<br>Virginia  |  |   |  |  | 13b. COUNTY<br>Fairfax   |  | 13c. CITY OR TOWN<br>Reston   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>George Glazebrook Tracy  |  |   |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Annette Louise Laney   |  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>N/A  |  | 16b. SOCIAL SECURITY NO.<br>N/A   |  | 17. INFORMANT ADDRESS<br>George G. Tracy See item 13   |  |  |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Anencephalopathy</u><br>7400 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) }<br>DUE TO, OR AS A CONSEQUENCE OF (c) }                           |  |   |  |  |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |  |   |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |   |   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June 17</u> , 19 <u>81</u> , to <u>June 17</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>June 17</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |  |   |   |   |  |
| 22b. SIGNATURE<br>LT C. J. Conlon MC USNR   |  |   |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   | 22c. DATE SIGNED<br>June 18 1981                    |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>LT C. J. CONLON MC USNR  |  |   |  |  | 22e. ADDRESS<br>National Naval Medical Center, Bethesda, Md.   |  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation  |  | 23b. DATE<br>June 18 1981   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>National Naval Med. Cen. Bethesda Montgomery   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                              |   |   |   |  |
| 24. FUNERAL DIRECTOR NAME<br>BP   |  |   |  |  | 25. DATE REC'D BY REGISTRAR<br>JUN 23 1981   |  |   |   |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |  |  |                     |  |  |
|---|--|---|--|---|--|--|---------------------|--|--|
| CERTIFICATE OF DEATH  |  |   |  |   |  |  |                     |  |  |
| REG. NO. 8 1 1 6 4 7 9  |  |   |  |   |  |  |                     |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Stella Mitchell Trevarrow  |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>June 15, 1981         |  | 2b. HOUR<br>4 P. M. |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Caucasian  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>November 12, 1917   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>83 YRS  |                     | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Michigan   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>United States   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County, MD.   |                     |  |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>6816 Massena Court |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife  |                     | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |  |  |                     |  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Montgomery   |  | 13c. CITY OR TOWN<br>Bethesda   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                     | 13e. STREET ADDRESS<br>6816 Massena Court  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William C. Mitchell   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ruth Keskey |  |                     |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>374-38-9678   |  | 17. INFORMANT<br>ADDRESS<br>William M. Trevarrow, Same as 13  |  |  |                     |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Emphysema</u><br>4920<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>10 years |  |   |  |   |  |  |                     |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |  |   |  |  |                     |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |                     |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |                     |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/12</u> 19 <u>81</u> to <u>6/15</u> 19 <u>81</u> , that (I) (we) saw the deceased alive on <u>6/12</u> 19 <u>81</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |                     |  |  |
| 22b. SIGNATURE<br>Dr Joseph Kenrick   |  |   |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                     | 22c. DATE SIGNED<br>6/15/81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr JOSEPH KENRICK  |  |   |  | 22e. ADDRESS<br>6450 Wisconsin Ave, Bethesda, Md  |  |  |                     |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation  |  | 23b. DATE<br>June 16, 1981  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Metropolitan Crematory  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Alexandria, Virginia   |                     |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>ROBERT A. PUMPHREY FUNERAL HOMES, P. A., Bethesda, Maryland   |  |   |  | 25a. DATE RECEIVED BY REGISTRAR<br>JUN 19 1981  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |                     |  |  |

5901



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

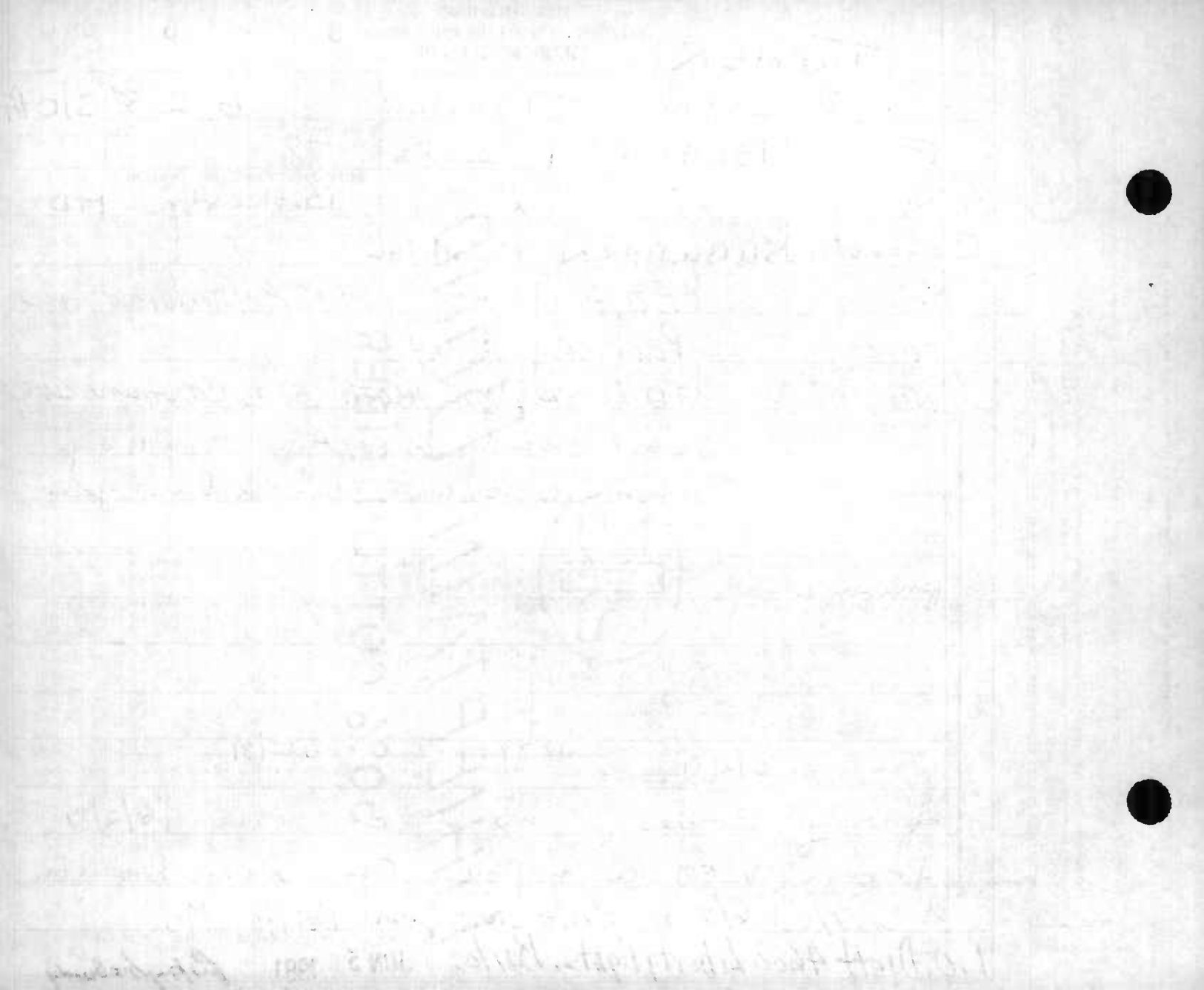
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

3

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |  |   |   |  |  |  |
|--|--|--|--|--|---|---|--|--|--|
| CERTIFICATE OF DEATH   |  |  |  |  |   |   |  |  |  |
| 1. FOR STATE REGISTRAR <u>TURNER</u>   |  |  |  |  | REG. NO.  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <u>TURNER</u><br><u>EVELYN</u>   |  |  |  |  | 2a. DATE OF DEATH<br>MONTH <u>6</u> DAY <u>28</u> YEAR <u>1981</u><br>2b. HOUR <u>3:10 PM</u> |   |  |  |  |
| 3. SEX <u>F</u>  |  | 4. RACE <u>BLACK</u>   |  | 5. DATE OF BIRTH<br>MONTH <u>1</u> DAY <u>2</u> YEAR <u>03</u>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>78</u> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS <u></u> DAYS <u></u> HOURS <u></u> MIN. <u></u>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>Balto., Md.</u>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Bethesda</u> <u>MD.</u>                              |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><u>Bethesda</u>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>SUBBARN HOSPITAL</u> |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <u>Md.</u>  |  | 13b. COUNTY <u></u>  |  | 13c. CITY OR TOWN <u>Balto</u>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><u>3817 Rolandview Ave</u>  |  |
| 14. FATHER'S NAME<br>FIRST <u>James</u> MIDDLE <u></u> LAST <u>Parker</u>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <u>Mary</u> MIDDLE <u></u> LAST <u></u>  |  |  |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <u>NO</u>   |  | 16b. SOCIAL SECURITY NO.<br><u>212 72 5870</u>   |  | 17. INFORMANT ADDRESS<br><u>Doris Heath 5020 Carmine Ave</u>   |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u><br><u>4360</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>arterio sclerosis cerebral vascular disease years</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>11 days</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>pneumonia</u>  |  |  |  |  |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <u>19</u>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/79</u> , 19____, to <u>6/2/81</u> , 19____, that (I) (we) lost saw the deceased alive on <u>6/2/81</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |   |   |  |  |  |
| 22b. SIGNATURE<br><u>Jeremy V Cooke</u>  |  |  |  | DEGREE <u>MD</u><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   |  | 22c. DATE SIGNED<br><u>6/2/81</u>  |  |
| 22d. PHYSICIAN'S NAME (OR PRINT)<br><u>Jeremy V. Cooke</u>   |  |  |  | 22e. ADDRESS<br><u>10400 Conn Ave. Kenilworth</u>  |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE<br><u>6/8/81</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Balto. Nat. Cem.</u>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Balto., Md.</u>                                |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <u>L.O. Dyett</u> ADDRESS <u>4600 Liberty Hgts. Balto.</u>  |  |  |  | 25a. DATE REC'D BY REGISTRAR<br><u>JUN 5 1981</u>  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Patricia...</u>  |  |  |  |





**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 WEST BALTIMORE, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1648

|   |  |  |  |   |  |   |  |                            |  |                       |  |                                       |  |                         |  |          |  |          |  |
|---|--|--|--|---|--|---|--|----------------------------|--|-----------------------|--|---------------------------------------|--|-------------------------|--|----------|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST  |  | MIDDLE  |  | LAST  |  | 20. DATE KNOWN<br>OF DEATH |  | 21. ESTI-<br>MATED    |  | 22. MONTH                             |  | 23. DAY                 |  | 24. YEAR |  | 25. HOUR |  |
| Patrick   |  | Alexander  |  | Twigg   |  |   |  | 6                          |  | 19                    |  | 81                                    |  |                         |  |          |  |          |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)                                   |  | IF UNDER 1 YR.             |  | IF UNDER 24 HRS.      |  | 7c. DATE<br>PRONOUNCED<br>DEAD        |  | 8. MONTH                |  | 9. DAY   |  | 10. YEAR |  |
| Male  |  | White  |  | JUNE 26 1955  |  | 25 YRS.   |  |                            |  |                       |  | 7                                     |  | 31                      |  | 81       |  | Noon     |  |
| 11. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)  |  | 12. CITIZEN OF WHAT COUNTRY?   |  | 13. MARRIED   |  | 14. NEVER MARRIED                                   |  | 15. WIDOWED                |  | 16. DIVORCED          |  | 17. BALTIMORE CITY OR COUNTY OF DEATH |  |                         |  |          |  |          |  |
| MARYLAND  |  | USA  |  |   |  |   |  |                            |  |                       |  | Montgomery County,                    |  |                         |  |          |  |          |  |
| 18. CITY OR TOWN OF DEATH   |  | 19. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                         |  | 20. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)   |  | 21. KIND OF BUSINESS<br>OR INDUSTRY                 |  |                            |  |                       |  |                                       |  |                         |  |          |  |          |  |
| Clarksberg  |  | 21510 Clarksberg Rd - in pond  |  | BETHESDA NAVAL HOSPITAL   |  |   |  |                            |  |                       |  |                                       |  |                         |  |          |  |          |  |
| 22. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                      |  | 23. STATE  |  | 24. COUNTY  |  | 25. CITY OR TOWN                                    |  | 26. INSIDE CITY LIMITS?    |  | 27. STREET ADDRESS    |  |                                       |  |                         |  |          |  |          |  |
| MARYLAND  |  | MONTGOMERY   |  | CLARKSBURG  |  | YES   |  | NO                         |  | 21510 CLARKSBURG ROAD |  |                                       |  |                         |  |          |  |          |  |
| 28. FATHER'S NAME   |  | 29. MOTHER'S MAIDEN NAME   |  | 30. ADDRESS   |  |   |  |                            |  |                       |  |                                       |  |                         |  |          |  |          |  |
| JOSEPH  |  | TERESA   |  | JOSEPH TWIGG RFD#9 CHRISTIE ROAD CUMBERLAND   |  |   |  |                            |  |                       |  |                                       |  |                         |  |          |  |          |  |
| 31. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |  | 32. SOCIAL SECURITY NO.  |  | 33. INFORMANT   |  | 34. ADDRESS   |  |                            |  |                       |  |                                       |  |                         |  |          |  |          |  |
| NO  |  | 218-62-5875  |  | JOSEPH TWIGG  |  | RFD#9 CHRISTIE ROAD CUMBERLAND                      |  |                            |  |                       |  |                                       |  |                         |  |          |  |          |  |
| 35. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:                            |  | 36. IMMEDIATE CAUSE (a)  |  | 37. DUE TO, OR AS A CONSEQUENCE OF  |  | 38. APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |                            |  |                       |  |                                       |  |                         |  |          |  |          |  |
| 7 9109  |  | DROWNING   |  | DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |                            |  |                       |  |                                       |  |                         |  |          |  |          |  |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause lost.                            |  | (b)  |  | DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |                            |  |                       |  |                                       |  |                         |  |          |  |          |  |
|   |  | (c)  |  |   |  |   |  |                            |  |                       |  |                                       |  |                         |  |          |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1      |  |  |  |   |  |   |  |                            |  |                       |  |                                       |  |                         |  |          |  |          |  |
| 39. DATE OF OPERATION   |  | 40. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  | 41. AUTOPSY?  |  | YES   |  | NO                         |  |                       |  |                                       |  |                         |  |          |  |          |  |
| 42. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH |  | 43. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>? P.M. 6 19 81   |  | 44. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  | subject drowned                                     |  |                            |  |                       |  |                                       |  |                         |  |          |  |          |  |
| 45. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE<br>AT WORK <input checked="" type="checkbox"/>              |  | 46. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)  |  | 47. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  | 21510 Clarksberg Rd., Clarksberg, Mont., MD.        |  |                            |  |                       |  |                                       |  |                         |  |          |  |          |  |
| 48. I certify that I took charge of the remains described above, held on  |  | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  | death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | TITLE (SPECIFY)<br>M.D. Deputy Chief                |  | MEDICAL EXAMINER           |  | DATE<br>SIGNED 7/5/81 |  |                                       |  |                         |  |          |  |          |  |
| 49. ACTUAL<br>SIGNATURE   |  | Thomas D. Smith, M.D.  |  | ADDRESS   |  | 111 Penn ST. Balto., MD.                            |  |                            |  |                       |  |                                       |  |                         |  |          |  |          |  |
| 50. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 51. DATE   |  | 52. NAME OF CEMETERY OR CREMATORY   |  | 53. LOCATION<br>CITY OR TOWN COUNTY STATE           |  | BURIAL                     |  | JULY 7 1981           |  | HILLCREST BURIAL PARK                 |  | CUMBERLAND ALLEGANY MD. |  |          |  |          |  |
| 54. FUNERAL DIRECTOR<br>NAME  |  | SILCOX-MERRITT   |  | CUMBERLAND, MARYLAND  |  | 55. DATE RECD                                       |  | JUL 9 1981                 |  | BY REGISTRAR          |  | IN REGISTRAR'S SIGNATURE              |  |                         |  |          |  |          |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be made.

3

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

81

16

48

22

REG. NO.

|   |  |   |  |   |  |  |   |   |  |
|---|--|---|--|---|--|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>CONCEPCION P. VAZQUEZ  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>6-25-81                         |   |  | 2b. HOUR<br>12:05 PM   |   |   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>MEXICAN  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8/18/1949   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>69 YRS  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MEXICO   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>MEXICO  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY COUNTY, MD.                       |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>TAKOMA PARK  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>WASHINGTON ADVENTIST |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>NONE             |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>NONE   |  |
| 13a. STATE<br>MD  |  |   | 13b. COUNTY<br>P.G.  |   | 13c. CITY OR TOWN<br>LANNAM  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 13e. STREET ADDRESS<br>9008 SPRING AVE.   |  |   | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>RAFAEL (N) DE LA PEÑA        |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>PATHERIA B N FUNTES                 |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>451-74-3947 |   |  | 17. INFORMANT<br>ADDRESS<br>RAFAEL VAZQUEZ 9008 SPRING AVE                           |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) 1749<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>myocardial infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>myocardial infarction</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |  |   |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT HOME  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from JAN 10, 1979, to JUNE 25, 1981, that (I) (we) last saw the deceased alive on JUNE 25, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |   |   |  |
| 22b. SIGNATURE<br><u>Lewis H. Dennis</u>  |  |   | DEGREE   |   |  | 22c. DATE SIGNED<br>6-25-81  |   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>LEWIS H. DENNIS, M.D.  |  |   | 22e. ADDRESS<br>831 UNIVERSITY BLVD, EAST<br>SILVER SPRING, MD. 20903  |   |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |   | 23b. DATE<br>6-27-1981   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>SAN ANGELO                               |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>N. ARLING MEXICO TAMPA                            |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Vasquez Funeral Home Madero No. 3352  |  |   | 25a. DATE RECEIVED BY REGISTRAR<br>JUN 26 1981                         |   | 25b. SIGNATURE<br><u>[Signature]</u>   |  |   |   |  |



EMBAJADA DE MEXICO  
WASHINGTON, D.C.

Nº 439292

Derechos \$ 250.00 M.N.

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SERVICIO CONSULAR MEXICANO

El suscrito EMB. ALVARO CARRANCO AVILA, Jefe de la Sección Consular  
Cónsul Embajada de México en WASHINGTON, D.C.

\_\_\_\_\_, certifica que la firma que antecede  
es de Lewis H. Dennis, M.D., Funcionario del Departamento de Sa-  
lud e Higiene del Estado de Maryland en los Estados Unidos de América.

y la misma que acostumbra usar en todos los documentos que autoriza; por lo cual se le  
debe dar fe y crédito.

WASHINGTON, D.C. de 27 junio de 1981

NOTA: Esta oficina no osume  
responsabilidad alguna por el  
contenido del documento onexo.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 6 4 8 3

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |  |   |
|--|--|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>IRMA P. WALLACE   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>June 6 81                                     |  | 2b. HOUR<br>11:57 A.M.  |
| 3 SEX<br>FEMALE  | 4 RACE<br>CAUCASIAN  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>MARCH 16, 1885  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>96 YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VIRGINIA  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY MD.                            |  |   |
| 10. CITY OR TOWN OF DEATH<br>WHEATON   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3011 HENDERSON AVENUE |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>PAYROLL CLERK |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>CIVIL SERVICE  |
| 13a. STATE<br>MARYLAND   |  |   | 13b. COUNTY<br>MONTGOMERY   | 13c. CITY OR TOWN<br>WHEATON   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOHN C. PHILLIPS   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>LULA WATSON                      |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>228-22-4127  | 17. INFORMANT<br>daughter ADDRESS<br>ELISABETH W. BALSINGER SAME AS 13            |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>4409 IMMEDIATE CAUSE (a) <u>Generalized Arteriosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Old Age</u>  |  |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>Years</u><br><u>Years</u>   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Pneumonia - April 81</u>   |  |   |   |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7-7</u> 19 <u>80</u> to <u>6-8</u> 19 <u>81</u> , that (II) (we) last saw the deceased alive on <u>5-19</u> 19 <u>81</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) and did not view the body after death. |  |   |   |  |   |
| 22b. SIGNATURE<br><u>Morris Parry M.D.</u>   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |   | 22c. DATE SIGNED<br><u>6-8-81</u>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Morris Parry M.D.</u>  |  | 22e. ADDRESS<br><u>11602 Georgia Ave Silver Spring Md</u>   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  | 23b. DATE<br><u>6/11/81</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br>PARKLAWN CEMETERY   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>ROCKVILLE MONT MD.                     |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>FRANCIS J. COLLINS</u>  |  | ADDRESS<br><u>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</u>   |   | 25a. DATE REC'D. BY REGISTRAR<br><u>JUN 12 1981</u>                                  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8 1 1 6 4 8 4   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>David W. Walter   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>JUNE 24 81  |  | 2b. HOUR<br>9 A M  |  |
| 3 SEX<br>MALE   |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>8 6 21   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>59 YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>TAKOMA PARK  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>WASHINGTON ADVENTIST HOSPITAL |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SAFEMART STORE   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>FOOD  |  |
| 13a. STATE<br>MD  |  |   |  | 13b. COUNTY<br>PR. GEO.   |  | 13c. CITY OR TOWN<br>HYATTSVILLE   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>WHITNEY WALTER   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>BEATRICE WEAVER   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>577-18-7897   |  | 17. INFORMANT ADDRESS<br>CHARLES H. JOHNSON - 17117 N. HAVE SS. MD  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Pneumonia<br>4860<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>8 days |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (he (this hospital) attended the deceased from 6/18 1981, to 6/24 1981, that (I) (we) lost saw the deceased alive on 6/23 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Alfred Munzer MD  |  |   |  | DEGREE<br>MD  |  | 22c. DATE SIGNED<br>6/24/81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Alfred Munzer MD   |  |   |  | 22e. ADDRESS<br>7600 Carroll Avenue Takoma Park Md  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  | 23b. DATE<br>JUN 26 1981  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>George Washington Cemetery  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Adelphi Md  |  |
| 24. FUNERAL DIRECTOR'S NAME<br>Edward Paul Hertz  |  |   |  | 25a. DATE REC'D BY REGISTRAR<br>JUN 29 1981   |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

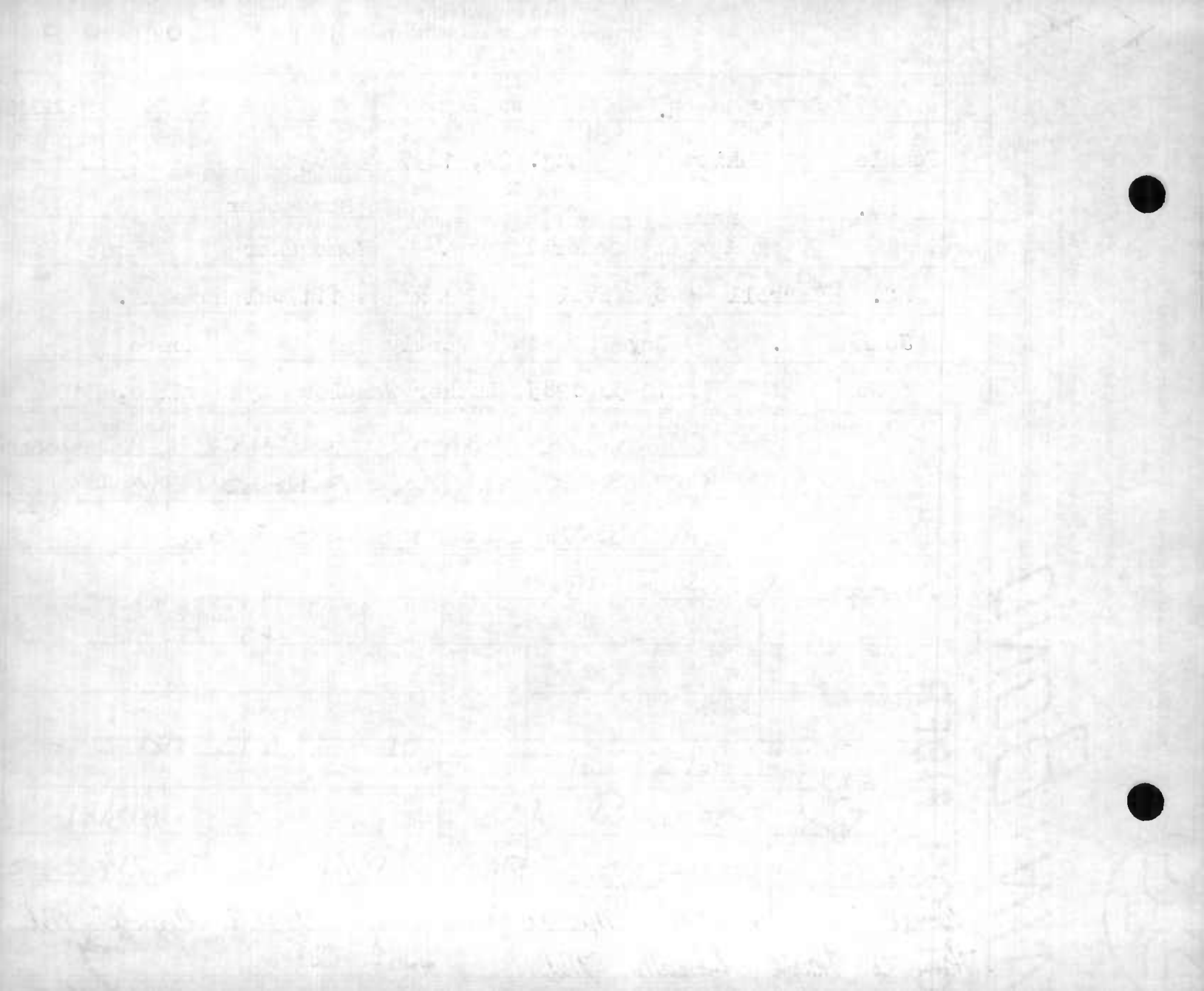
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |  |  |   |  |   |  |  |
|--|--|---|--|--|--|---|--|---|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>Annie R. Wampler</b>                    |  |   | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>6 3 81</b>                |  |  | 2b HOUR<br><b>5:22AM</b>  |  |   |  |  |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>White</b>  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Aug. 27, 1897</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b> YRS                                     |  | 7a IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.    |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>                           |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                        |  |   |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Olney</b>   |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Montgomery General Hosp.</b> |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Home</b> |  |  |
| 13a STATE<br><b>Md.</b>  |  |   | 13b CITY OR TOWN<br><b>Sykesville</b>                              |  | 13c INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13d STREET ADDRESS<br><b>6111 Oklahoma Rd.</b> |   |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John T. Day</b>                      |  |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sally Reese</b> |  |  |   |  |   |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b> |  |   | 16b SOCIAL SECURITY NO.<br><b>212 50 0285</b>                      |  | 17 INFORMANT<br>ADDRESS<br><b>Luther Wampler Sykesville, Md</b>                                |   |  |   |  |  |

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic renal failure</b><br><b>4039</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Unilateral renal disease</b><br>(c) <b>Hypertensive vascular disease</b>   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 years</b><br><b>10 + years</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>Cancer of colon, 1980</b>  |  |   |  |  |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)        |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                     |  |
| 22a I certify that (1) this hospital attended the deceased from <b>6/3</b> 19 <b>81</b> to <b>6/13</b> 19 <b>81</b> , that (1) <input checked="" type="checkbox"/> saw the deceased alive on <b>6/13</b> 19 <b>81</b> , and that in my <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (1) <input checked="" type="checkbox"/> did not view the body after death. |  |   |  |  |  |
| 27b SIGNATURE<br><b>[Signature]</b> MD  |  |   |  | 27c DATE SIGNED<br><b>6/13/81</b>  |  |
| 27d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>John G. Lodmell, MD.</b>   |  |   |  | 27e ADDRESS<br><b>18111 Prince Philip Dr. Olney, Md 20832</b>                        |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b DATE<br><b>6-5-81</b>   |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Methodist Lutheran Cemetery</b>              |  |
| 23d LOCATION<br>CITY OR TOWN<br><b>Burth, Carroll</b>   |  | 23e STATE<br><b>Md.</b>   |  | 23f COUNTY<br><b>Carroll</b>   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Harry W. Haight</b>   |  |   |  | 24b ADDRESS<br><b>Sykesville, Md.</b>  |  |
| 25a DATE REC'D. BY REGISTRAR<br><b>JUN 9 1981</b>   |  |   |  | 25b REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                      |  |

MEDICAL CERTIFICATION

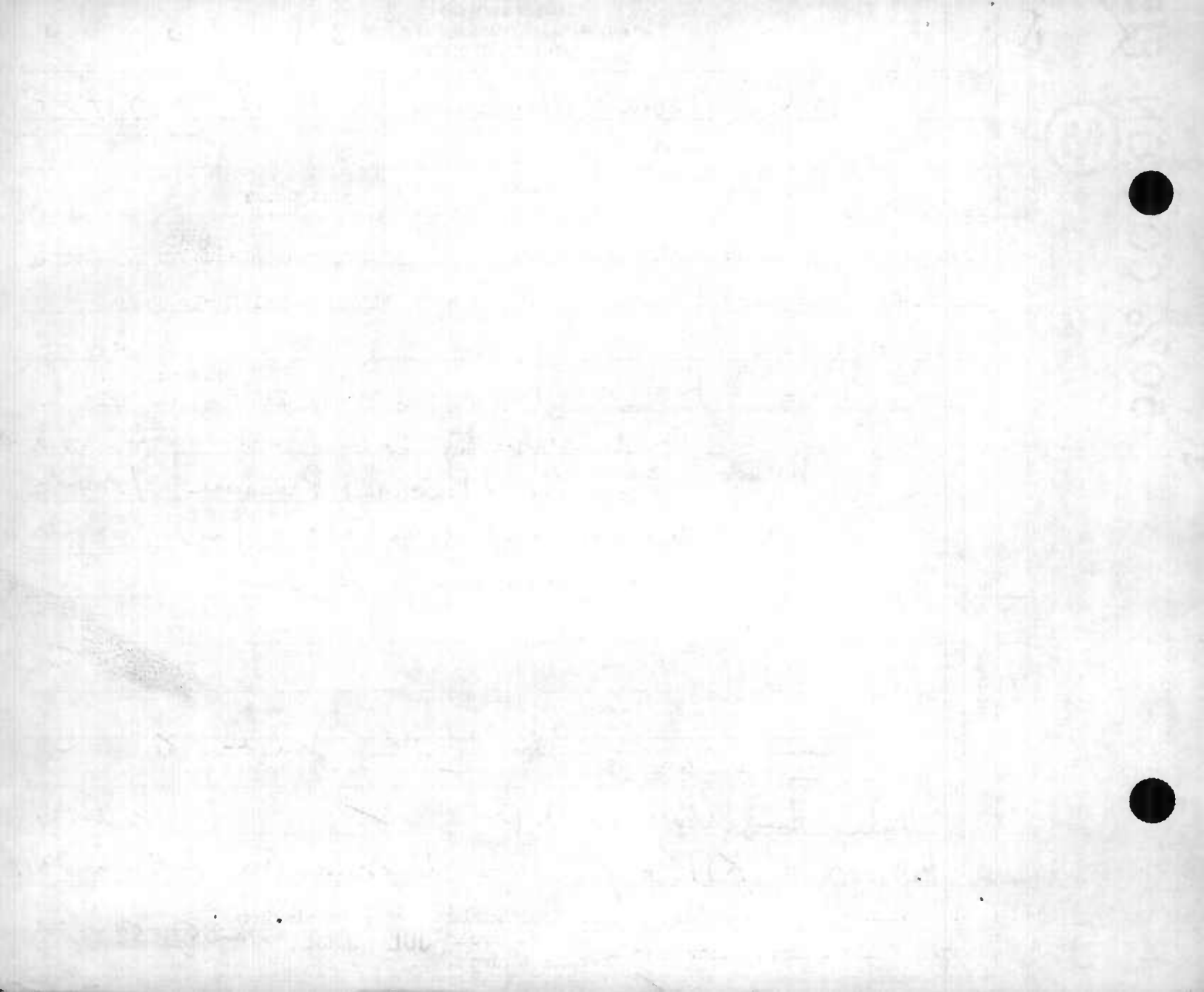


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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR STATE REGISTRAR  |  | STATE OF MARYLAND   |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  | 8 1 1 6 4 8 6   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)   |  | 2a. DATE OF DEATH   |  | 3. SEX  |  | 4. RACE   |  |
| John Nevin Waugaman, II  |  | (June) 6 26 81 4:30 P <sub>M</sub>  |  | Male  |  | Caucasian   |  |
| 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 8. CITIZEN OF WHAT COUNTRY?   |  |
| August 16 1916   |  | 64 YRS  |  | Pennsylvania  |  | USA   |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH   |  | 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  |  | 12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)        |  |
| Montgomery   |  | Potomac   |  | 11916 Jubal Early Court   |  | Corporate Executive-DPC Corp.                                       |  |
| 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  |
| Maryland   |  | Montgomery  |  | Potomac   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |  |
| John Nevin Waugaman, I   |  | Rhea Hoffmeier  |  | Yes   |  | 196-09-4541   |  |
| 17. INFORMANT  |  | ADDRESS   |  | 17a. DATE OF OPERATION  |  | 17b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |
| Gertrude A. Waugaman   |  | 11916 Jubal Early Ct.   |  |   |  |   |  |
| 18. CAUSE OF DEATH   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                      |  | 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |
| PART I. DEATH WAS CAUSED BY:   |  |   |  |   |  |   |  |
| IMMEDIATE CAUSE (a)  |  | 1 month   |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  | 1 month   |  |   |  |   |  |
| (b) Increased Intracranial Pressure  |  |   |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  | 1 month   |  |   |  |   |  |
| (c) Cerebral Metastases Carcinoma of Lung  |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |  |
| Pneumonia of Lung  |  |   |  |   |  |   |  |
| 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?                    |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY   |  |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                          |  |   |  | HOUR A.M. MONTH DAY YEAR  |  |
|  |  |   |  |   |  | P.M. 19   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  | 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION   |  |
|  |  | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  |   |  | STREET CITY OR TOWN COUNTY STATE                                    |  |
|  |  |   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 6 1981, to Jan 26 1981, that (I) (we) saw the deceased alive on Jan 6 1981 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE  |  | DEGREE  |  | 22c. DATE SIGNED  |  |
|  |  | William H. Kilgus   |  | M.D.  |  | Jan 26 1981   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS  |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE   |  |
| William H. Kilgus  |  | 8218 Wisconsin Ave Bethesda 20814   |  | Cremation   |  | 6/29/81   |  |
| 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  | 24. FUNERAL DIRECTOR  |  | 25. DATE RECD. BY REGISTRAR   |  |
| Lee Crematorium  |  | Washington D.C.   |  | Murphy Falls Church Funeral Home  |  | JUL 3 1981  |  |
|  |  |   |  | Falls Church, Va.   |  |   |  |

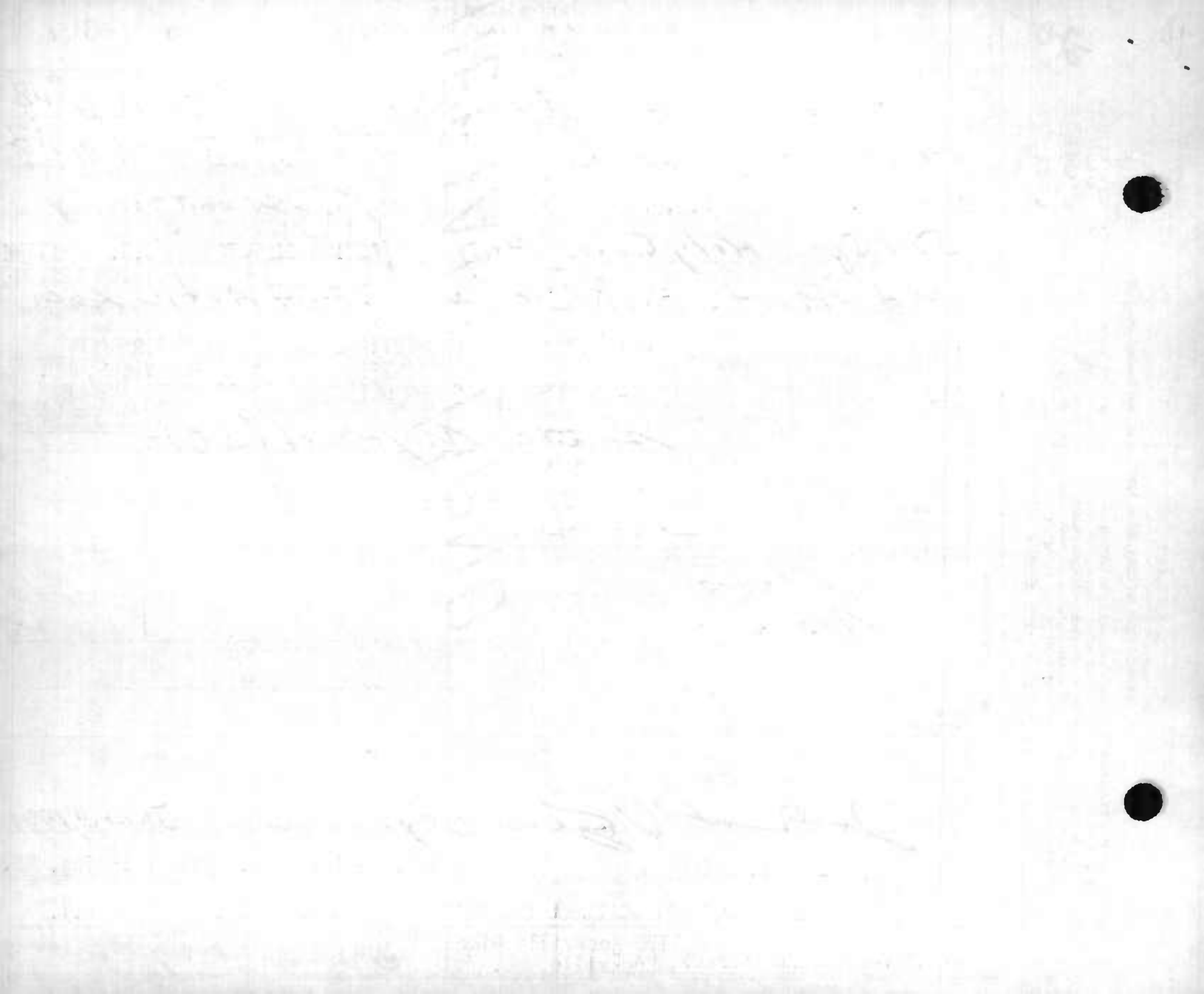


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                     |  |   |  |   |  |   |  | 16487  |  |
|--|--|---------------------|--|---|--|---|--|---|--|--|--|
| FOR<br>STATE<br>REGISTRAR  |  |                     |  |   |  |   |  |   |  | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Andrew H. Weissler</b>  |  |                     |  |   |  |   |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> <b>June 8, 1981</b>   |  |
| 3. SEX<br><b>M</b>   |  | 4. RACE<br><b>W</b> |  | 5. DATE OF BIRTH<br>MONTH <b>Aug</b> DAY <b>20</b> YEAR <b>51</b>   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>31</b> YRS. |  | 7. IF UNDER 1 YR.<br>MONTHS <b>0</b> DAYS <b>0</b>  |  | 7b. HOUR<br><b>1:30</b> PM   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NEW YORK</b>   |  |                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 2c. DATE PRONOUNCED DEAD<br><b>June 8, 1981</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>  |  |                     |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN LAUNCH FACILITY, GIVE STREET ADDRESS)<br><b>Holy Cross Hosp.</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>ACTING DIRECTOR</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. MARITIME COMMISSION</b>   |  |
| 13a. STATE<br><b>MD</b>  |  |                     |  | 13b. COUNTY<br><b>Mont.</b>   |  |   |  | 13c. CITY OR TOWN<br><b>Rockville</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 14. FATHER'S NAME<br>FIRST <b>FRANK</b> MIDDLE <b>WEISSLER</b> LAST <b>WEISSLER</b>  |  |                     |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>HENRIETTA</b> MIDDLE <b>BIRNBAUM</b> LAST <b>BIRNBAUM</b>  |  |   |  | 13e. STREET ADDRESS<br><b>13414 Artic Avenue</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>YES</b>   |  |                     |  | 16b. SOCIAL SECURITY NO.<br><b>094-22-5516</b>  |  |   |  | 17. INFORMANT (WIFE)<br><b>ELEANOR WEISSLER</b>   |  |  |  |
| (IF YES, GIVE WAR OR DATES)<br><b>KOREA</b>  |  |                     |  | ADDRESS <b>ROCKVILLE, MD.</b>   |  |   |  | 17a. ADDRESS<br><b>13414 ARTIC AVENUE</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                  |  |                     |  |   |  |   |  |   |  | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>None</b> |  |
| 19a. DATE OF OPERATION<br><b>None</b>  |  |                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?<br><b>None</b>  |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                     |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |                     |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |                     |  |   |  |   |  |   |  | TITLE (SPECIFY)<br><b>John S. Rogers, M.D.</b> MEDICAL EXAMINER  |  |
| ACTUAL SIGNATURE <b>John S. Rogers</b>   |  |                     |  |   |  |   |  |   |  | DATE SIGNED <b>June 8, 1981</b>  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>JOHN S. ROGERS</b>  |  |                     |  |   |  |   |  |   |  | ADDRESS <b>1919 Seminary Rd., Silver Spring, MD.</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  |                     |  | 23b. DATE<br><b>JUNE 10, 1981</b>   |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>WELLWOOD CEMETERY</b>  |  |  |  |
| 23d. LOCATION<br>CITY OR TOWN<br><b>FARMINGDALE,</b>   |  |                     |  | COUNTY<br><b>N.Y.</b>   |  |   |  | 23e. DATE REC'D. BY REGISTRAR<br><b>JUN 12 1981</b>   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>DANZANSKY-GOLDBERG CHAPELS</b> ADDRESS <b>1170 Rockville Pike, Rockville, MD.</b>  |  |                     |  |   |  |   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John S. Rogers</b>  |  |









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## CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |  |  |   |  |  |   |  |  |  |
|--|--|--|--|---|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>E. Rebecca Whisman</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>June 3 1981</b>  |   |  | 2b. HOUR<br><b>7:20 A.M.</b>   |   |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 13 '19</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>61 yrs.</b>  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rockville</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Shady Grove Adventist Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>N.I.H.</b>   |  |  |
| 13a. STATE<br><b>Md.</b>   |  |  | 13b. COUNTY<br><b>Montgomery</b>   |   | 13c. CITY OR TOWN<br><b>Dickerson</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>21110 Peach Tree Rd.</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>David Edward Biddinger</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Nina Pauline Boone</b>  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>-</b>                              |   | 17. INFORMANT<br><b>Howard E. Whisman</b>                                      |  | 17b. ADDRESS<br><b>21110 Peach Tree Rd. Dickerson, Md. 20753</b>                                |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebro-vascular hemorrhage</b><br><b>4310</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Hypertension</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Acute anemia, severe arterial disease</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>30 hours</b> |  |  |  |   |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (to)   |  |  |  |   |  |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>June 3 1981</b>   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Acute anemia, severe arterial disease</b> |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2) |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                           |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>June 3 1981</b> to <b>June 3 1981</b> , that (I) (we) last saw the deceased alive on <b>June 3 1981</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>John G. Fawcett</b>   |  |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>6/3/81</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOHN G. FAWCETT</b>  |  |  |  |   |  | 22e. ADDRESS<br><b>16610 SUGARLAND Rd. Boyds, Md. 20720</b>  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>6/5/81</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Union Chapel Cemetery</b>             |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Libertytown Md.</b>                            |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Gartner Sandison F. H. Gaithersburg, Md. 20760</b>  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 9 1981</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |   |  | 8 1 1 6 4 9 0 |  |
|--|--|--|--|--|--|--|--|---|--|---------------|--|
| FOR<br>1- STATE<br>REGISTRAR   |  | REG. NO.   |  |  |  |  |  |   |  |               |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST MIDDLE LAST<br>Carrie C. White   |  |  |  | 2a DATE OF DEATH MONTH DAY YEAR<br>6/8/81  |  | 2b HOUR<br>2:34 M   |  |               |  |
| 3 SEX<br>FEMALE  |  | 4 RACE<br>WHITE  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>6 1 90   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>91   |  | 7a UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |               |  |
| 7b BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Washington D.C.  |  | 7c CITIZEN OF WHAT COUNTRY?<br>U.S.  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery Co. MD.                                      |  |   |  |               |  |
| 10 CITY OR TOWN OF DEATH<br>Rockville, Md.   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Potomac Valley Nursing Home |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                   |  | 12b KIND OF BUSINESS OR INDUSTRY<br>HOME  |  |               |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE   |  | 13b COUNTY<br>Washington D.C.  |  | 13c CITY OR TOWN<br>Washington D.C.  |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e STREET ADDRESS<br>4545 Connecticut Ave. N.W.  |  |               |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Frank Coleman   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Carrie Duvall   |  |  |  |  |  |   |  |               |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>***  |  | 17 INFORMANT<br>Helen B. White Same as Item # 13   |  | ADDRESS  |  |   |  |               |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Chronic congestive Heart Failure</u><br>4140<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (d), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Arteriosclerotic Heart Disease</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 Mo |  |  |  |  |  |  |  |   |  |               |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |  |  |   |  |               |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |               |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |               |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |               |  |
| 22a I certify that (I) (this hospital) attended the deceased from <u>MAR 1978</u> , 19____, to <u>JUN 07</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>JUN 07</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) see the body after death.  |  |  |  |  |  |  |  |   |  |               |  |
| 22b SIGNATURE<br><u>Peyton R. Evans M.D.</u>   |  | DEGREE<br>M.D.   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                 |  |  |  | 22c DATE SIGNED<br>6-8-81   |  |               |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>Peyton R. Evans Jr   |  | 22e ADDRESS<br>4906 Mass Ave WASH DC 20016   |  |  |  |  |  |   |  |               |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b DATE<br>6/11/81  |  | 23c NAME OF CEMETERY OR CREMATORY<br>Congressional Cem.  |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>Washington, D.C.                                  |  |   |  |               |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Joseph Gawler's Sons, Inc.  |  | ADDRESS<br>5130 Wisc. Ave. N.W. Wash., D.C. 20016  |  | 25a DATE REC'D. BY REGISTRAR<br>JUN 11 1981  |  | 25b REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |   |  |               |  |

BP





| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  | REG. NO. 16491 |  |
|--|--|--|--|--|--|--|--|--|--|----------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>Gertrude McKinley White</b>  |  |  |  |  |  | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input checked="" type="checkbox"/> DAY <input type="checkbox"/> YEAR <b>6 6 1981</b> |  | 2b. HOUR <b>A-M</b>  |  |                |  |
| 3. SEX <b>Female</b>   |  | 4. RACE <b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>June 13, 1888 92 YRS.</b>   |  | 6. AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <b>92</b>   |  | 7c. DATE PRONOUNCED DEAD <b>June 10, 1981 1P-M</b>                               |  |                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Nebraska</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>   |  |  |  |                |  |
| 10. CITY OR TOWN OF DEATH <b>Cherry Chase</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3300 Leland St.</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>                                    |  |                |  |
| 13a. STATE <b>Maryland</b>   |  |  |  |  |  | 13b. COUNTY <b>Montgomery</b>  |  | 13c. CITY OR TOWN <b>Cherry Chase</b>  |  |                |  |
| 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  | 13e. STREET ADDRESS <b>3300 Leland Street</b>  |  |  |  |                |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles William McKinley</b>  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Caroline Wist</b>  |  |  |  |                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>   |  |  |  | 16b. SOCIAL SECURITY NO. <b>577-84-3217</b>  |  | 17. INFORMANT ADDRESS <b>James P. Morison, Jr., 2601 University Blvd. West, Wheaton, MD</b>  |  |  |  |                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Drowning</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. <b>Coronary Insufficiency</b><br>(b) <b>Coronary Insufficiency</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH           |  |  |  |  |  |  |  |  |  |                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |  |  |  |  |  |  |  |  |                |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>7 P.M. 6-6 1981</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Flt. heart attack in back seat.</b>                         |  |  |  |                |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Home</b>  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>3300 Leland St. - Ch. - Montgomery Md.</b>   |  |  |  |                |  |
| 22. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |  |  |  |  |  |  |  |  |                |  |
| ACTUAL SIGNATURE <b>John G. Ball</b>   |  |  |  | TITLE (SPECIFY) <b>Deputy</b>  |  | MEDICAL EXAMINER   |  | DATE SIGN <b>June 10, 1981</b>   |  |                |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>John G. Ball, M.D.</b>  |  |  |  | ADDRESS <b>Bethesda, Maryland 20014</b>  |  |  |  |  |  |                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>   |  |  |  | 23b. DATE <b>June 13, 1981</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan Crematory Alexandria, Virginia</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |                |  |
| 24. FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland</b>   |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>JUN 18 1981</b>   |  | 25b. SIGNATURE <b>Robert A. Pumphrey</b>   |  |                |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 6 4 9 2

1. FOR  
STATE  
REGISTRAR

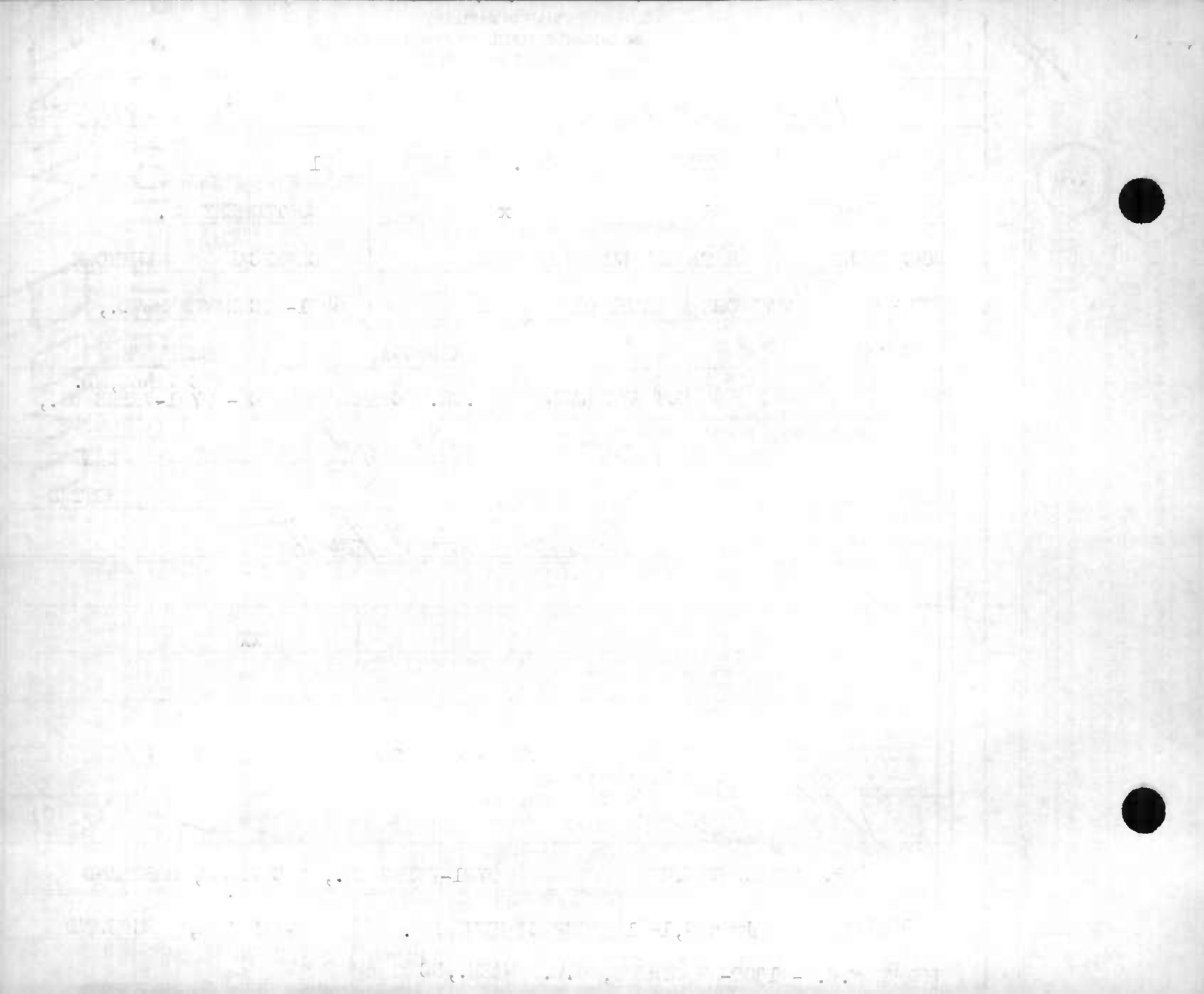
REG. NO.

|   |  |   |   |   |  |
|---|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARY Catherine WILL</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>June 6 1981</b>                              |   | 2b. HOUR<br><b>3:31 A.M.</b>   |
| 3. SEX<br><b>FEMALE</b>   | 4. RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JAN. 6 1890</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>91</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PENNSYLVANIA</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY CO.</b> MD.                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>ROCKVILLE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NATIONAL LUTHERAN HOME</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CLERICAL</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>UNKNOWN</b>  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>6401-LOCHRAVEN BLVD.,</b>  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>NEWTON</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>REBECCA ESHELMAN</b>            |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE YEAR OR DATES)<br><b>NONE</b>   |   | 17. INFORMANT ADDRESS<br><b>REV. DR. RICHARD HEMBROCK- 9701-VEIRS DR.,</b>                      |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b><br><b>4360</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <b>Hypertension</b><br>(c) <b>Coronary Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>DAYS</b><br><b>MONTHS</b>   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-23 19 81</b> to <b>6-6-19 81</b> , that (I) (we) lost <b>6-6-19 81</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |   |   |  |
| 22b. SIGNATURE<br><b>DR. THOMAS DOOLEY</b>  |  |   |   | 22c. DATE SIGNED<br><b>6-6-81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. THOMAS DOOLEY</b>   |  |   |   | 22e. ADDRESS<br><b>9701-VEIRS DR., ROCKVILLE, MARYLAND</b>                                      |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>JUNE 9, 1981</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>PROSPECT HILL CEM.</b>                                 |  |
| 23d. LOCATION<br>CITY OR TOWN<br><b>BALTIMORE, MARYLAND</b>   |  | 23e. COUNTY<br><b>BALTIMORE</b>   |   | 23f. STATE<br><b>MARYLAND</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>HYSONG F.H. - 1300- N STREET, N.W. WASH., DC</b>   |  | 24b. ADDRESS<br><b>1300- N STREET, N.W. WASH., DC</b>   |   | 24c. DATE REC'D. BY REGISTRAR<br><b>JUN 12 1981</b>   |  |
| 24d. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  | 24e. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |   |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer, death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |   |   |  |  |  |   |  |
|---|--|---|---|---|--|--|--|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>MURTLE A. WILSON</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6-11-81</b>                             |   |  | 2b. HOUR<br>MIN.<br><b>11 30 P M</b>   |  |   |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 9, 1901</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><b>80</b>                                 |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY CO. MD.</b>                    |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Suburban Hospital</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Cashier</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Glenn L.</b>  |  |
| 13a. STATE<br><b>Maryland</b>   |  |   | 13b. COUNTY<br><b>Montgomery Gaithersburg</b>                                     |   | 13c. CITY OR TOWN<br><b>Asbury Methodist Village</b>                           |  | 13d. STREET ADDRESS<br><b>Martin Co.</b>                           |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Henry Valentine</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Emma Burgemeister</b>         |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>    |  |   |  |
| 16b. SOCIAL SECURITY NO.<br><b>212 20 5638</b>  |  |   | 17. INFORMANT<br>ADDRESS<br><b>Mr. Ralph Wilson, Reisterstown, Md.</b>            |   |  |  |  |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>INTESTINAL OBSTRUCTION</b><br>5608<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ADHESIONS FROM APPENDICITIS</b><br>40 years<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>APPENDICITIS</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b> |  |   |   |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Malignant Melanoma</b>  |  |   |   |   |  |  |  |   |  |
| 19a. DATE OF OPERATION<br><b>6/10/81</b>  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Intestinal obstruction</b> |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                        |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)            |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |   |  |
| 22a. I certify that (1) [initial hospital] attended the deceased from [initial date] 19 [initial year] to [initial date] 19 [initial year], that (1) (we) last saw the deceased alive on [initial date] 19 [initial year] and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did not) view the body after death.              |  |   |   |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>[Signature]</b>  |  |   | 22c. DEGREE<br><b>[Signature]</b>   |   |  | 22d. DATE SIGNED<br><b>6/12/81</b>   |  | 22e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 22f. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. G. WARD</b>   |  |   | 22g. ADDRESS<br><b>6116 ROBINWOOD, BETHESDA, MD. 20034</b>                        |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>6/15/81</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore</b>                         |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b> |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Henry W. Jenkins &amp; Sons Co.</b><br>4905 York Road Balto., Md. 21212  |  |   |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 12 1981</b>                                  |  |   |  |

4005 York Road, Baltimore, Md. 21212  
Henry W. Jenkins & Sons Co.  
Baltimore, Md. 21212

Baltimore, Md.

No 212 20 5288 Mr. Ralph Wilson, Reisterstown, Md.

Henry Valentine Emma Gurneyster

Maryland Northampton, Githersburg

Glenn C. Martin Co.

Asbury Methodist Village

Maryland USA

June 1, 1961

80

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

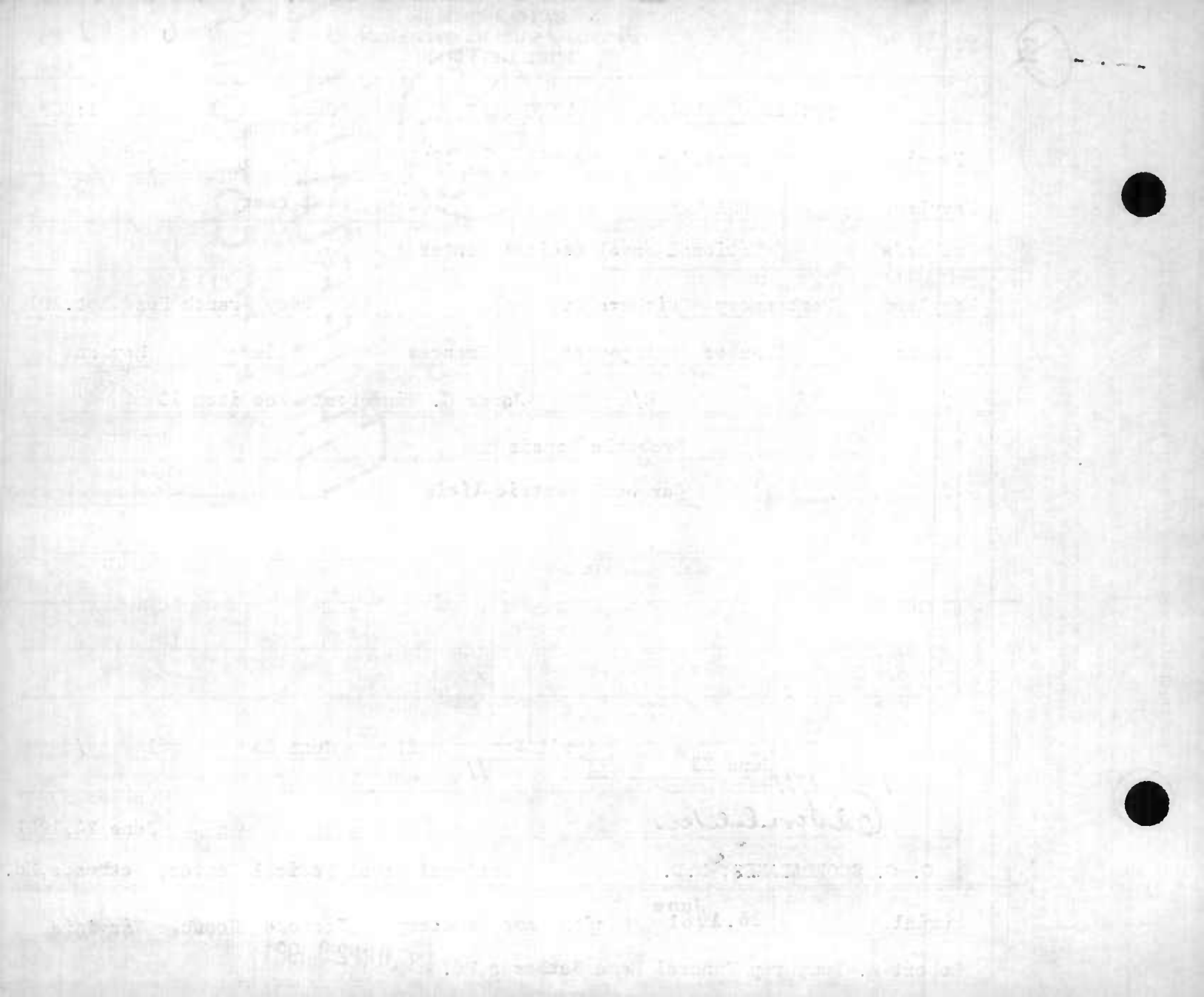
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |  |                          |                                      |                                |  |      |  |          |                                   |  |
|---|--|--|--|--|--------------------------|--------------------------------------|--------------------------------|--|------|--|----------|-----------------------------------|--|
| CERTIFICATE OF DEATH  |  |  |  |  |                          |                                      |                                |  |      |  |          |                                   |  |
| REG. NO.  |  |  |  |  |                          |                                      |                                |  |      |  |          |                                   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  |  |  | 2a. DATE OF DEATH        |                                      | MONTH                          |  | DAY  | YEAR   | 2b. HOUR |                                   |  |
| Cynthia Leigh WINGQUIST   |  |  |  |  | June                     |                                      | 23                             |  | 1981 | 1:00P  |          |                                   |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |                          | 6. AGE (IN YEARS LAST BIRTHDAY)      |                                | IF UNDER 1 YEAR  |      | IF UNDER 24 HRS.   |          |                                   |  |
| Female  |  | Caucasian  |  | April 4 1981   |                          | 0 YRS.                               |                                | 2 MONTHS   |      | 19 DAYS  |          |                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                          | 9. BALTIMORE CITY OR COUNTY OF DEATH |                                |  |      |  |          |                                   |  |
| Maryland  |  | USA  |  |  |                          | Montgomery MD.                       |                                |  |      |  |          |                                   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |                          |                                      |                                |  |      | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |          | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| Bethesda  |  | National Naval Medical Center  |  |  |                          |                                      |                                |  |      | N/A  |          |                                   |  |
| 13a. STATE  |  |  |  |  |                          |                                      |                                |  |      | 13b. CITY OR TOWN  |          | 13c. STREET ADDRESS               |  |
| Maryland  |  |  |  |  |                          |                                      |                                |  |      | Montgomery   |          | 413 Muddy Branch Road Apt. 201    |  |
| 14. FATHER'S NAME   |  |  |  |  | 15. MOTHER'S MAIDEN NAME |                                      |                                |  |      |  |          |                                   |  |
| James Charles Wingquest   |  |  |  |  | Frances Ellen Moylan     |                                      |                                |  |      |  |          |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  |  | 16b. SOCIAL SECURITY NO. |                                      | 17. INFORMANT ADDRESS          |  |      |  |          |                                   |  |
| N/A   |  |  |  |  | N/A                      |                                      | James C. Wingquest See item 13 |  |      |  |          |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |  |  |  |  |                          |                                      |                                |  |      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |          |                                   |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |  |                          |                                      |                                |  |      |  |          |                                   |  |
| IMMEDIATE CAUSE (a) Probable Sepsis   |  |  |  |  |                          |                                      |                                |  |      |  |          |                                   |  |
| 3029 DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |                          |                                      |                                |  |      |  |          |                                   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last   |  |  |  |  |                          |                                      |                                |  |      |  |          |                                   |  |
| (b) Cerebral ventriculitis  |  |  |  |  |                          |                                      |                                |  |      |  |          |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |                          |                                      |                                |  |      |  |          |                                   |  |
| (c)   |  |  |  |  |                          |                                      |                                |  |      |  |          |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a  |  |  |  |  |                          |                                      |                                |  |      |  |          |                                   |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                          |                                      |                                | 20a. AUTOPSY?  |      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |          |                                   |  |
|   |  |  |  |  |                          |                                      |                                | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |      | YES <input type="checkbox"/> NO <input type="checkbox"/>       |          |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |                          |                                      |                                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |      |  |          |                                   |  |
|   |  |  |  | P.M. 19  |                          |                                      |                                |  |      |  |          |                                   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                          |                                      |                                | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |      |  |          |                                   |  |
|   |  |  |  |  |                          |                                      |                                |  |      |  |          |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from April 4 1981, to June 23 1981, that (I) (we) lost saw the deceased alive on June 23 1981, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. |  |  |  |  |                          |                                      |                                |  |      |  |          |                                   |  |
| 22b. SIGNATURE  |  |  |  |  |                          |                                      |                                | DEGREE   |      | 22c. DATE SIGNED   |          |                                   |  |
| G. C. SCORDALAKES, M.D.   |  |  |  |  |                          |                                      |                                |  |      | June 24, 1981  |          |                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  |  |                          |                                      |                                | 22e. ADDRESS   |      |  |          |                                   |  |
| G. C. SCORDALAKES, M.D.   |  |  |  |  |                          |                                      |                                | National Naval Medical Center, Bethesda, Md.                                   |      |  |          |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  |  | 23b. DATE  |                          | 23c. NAME OF CEMETERY OR CREMATORY   |                                | 23d. LOCATION CITY OR TOWN COUNTY STATE  |      |  |          |                                   |  |
| Burial  |  |  |  | June 26, 1981  |                          | Cedar Lawn Cemetery                  |                                | Roanoke Road Roanoke Virginia  |      |  |          |                                   |  |
| 24. FUNERAL DIRECTOR NAME   |  |  |  |  |                          | ADDRESS                              |                                | 25a. DATE RECEIVED BY REGISTRAR  |      | 25b. REGISTRAR'S SIGNATURE                                     |          |                                   |  |
| Robert A. Pumphrey Funeral Home   |  |  |  |  |                          | Bethesda, Md.                        |                                | JUN 29 1981  |      |  |          |                                   |  |





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE RETURNED TO THE DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                  |  |  |   |   |  |   |   |  | REG. NO. 16495  |  |
|--|------------------|--|--|---|---|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST <i>Olga</i> MIDDLE <i>Winokur</i> LAST <i>Winokur</i>  |                  |  |  |   |   |  |   |   |  | 2b. DATE KNOWN OF DEATH<br>MONTH <i>June</i> DAY <i>14</i> YEAR <i>81</i> |  |
| 3. SEX <i>F</i>  | 4. RACE <i>W</i> | 5. DATE OF BIRTH<br>MONTH <i>Jan</i> DAY <i>11</i> YEAR <i>92</i>  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <i>89</i> YRS.                        | IF UNDER 1 YR.<br>MONTHS <i>0</i> DAYS <i>0</i> HOURS <i>0</i> MIN <i>0</i>   | IF UNDER 24 HRS.<br>HOURS <i>0</i> MIN <i>0</i>   | 2c. DATE PRONOUNCED DEAD<br>MONTH <i>June</i> DAY <i>14</i> YEAR <i>81</i>             |   | 2d. HOUR OF DEATH<br>HOUR <i>9:30</i> MIN <i>0</i> SEC <i>0</i>                     |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Russia</i>   |                  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Montgomery</i> MD.                          |   |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Silver Spring</i>  |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Holy Cross Hosp</i> |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Ret-Bookkeeper</i> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Telephone Co</i>                            |  |   |  |
| 13a. STATE<br><i>MD</i>  |                  |  | 13b. COUNTY<br><i>Montgomery</i>   |   | 13c. CITY OR TOWN<br><i>Bethesda</i>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><i>2605 Honesty Way</i> |   |  |
| 14. FATHER'S NAME<br>FIRST <i>Aaron</i> MIDDLE <i>---</i> LAST <i>Winokur</i>  |                  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <i>Anna</i> MIDDLE <i>---</i> LAST <i>(Unknown)</i>   |   |  |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><i>No</i>   |                  |  | 16b. SOCIAL SECURITY NO.<br><i>159-03-3912</i>                           |   | 17. INFORMANT<br>ADDRESS<br><i>Arnold Winokur, Same address as # 13.</i>  |  |   |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Disseminated Intravascular Coagulation</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Gram Negative Sepsis</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |                  |  |  |   |   |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                              |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).<br><i>Fracture Rb Hip</i>  |                  |  |  |   |   |  |   |   |  |   |  |
| 19a. DATE OF OPERATION<br><i>None</i>  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                        |   |   |  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH   |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>6 PM 1 23 1981</i> |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br><i>Fell on her r &amp; b hip</i> |  |   |   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)              |   | 21f. LOCATION<br>STREET<br>CITY OR TOWN<br>COUNTY<br>STATE<br><i>Penn</i>   |  |   |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . |                  |  |  |   |   |  |   |   |  |   |  |
| ACTUAL SIGNATURE<br><i>John S. Rogers</i>  |                  |  | TITLE (SPECIFY)<br><i>M.D.</i>   |   |   | MEDICAL EXAMINER   |   |   | DATE SIGNED<br><i>June 15/81</i>               |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><i>John S. Rogers</i>  |                  |  | ADDRESS<br><i>Silver Spring, Montgomery Co., Md.</i>                     |   |   |  |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Cremation</i>  |                  |  | 23b. DATE<br><i>6/17/81</i>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Cedar Hill Crematory</i>   |  |   | 23d. LOCATION<br>CITY OR TOWN<br>COUNTY<br>STATE<br><i>Suitland, Maryland</i>       |  |   |  |
| 24. FUNERAL DIRECTOR<br><i>Joseph Gawler's Sons, Inc.</i><br><i>5130 Wisconsin Ave., NW, Washington, D.C. 20016</i>  |                  |  |  |   |   | 25a. DATE RECD BY REGIONAL   |   | 25b. REGIONAL SIGNATURE<br><i>JUN 17 1981</i>                                       |  |   |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                      |  |   |   |  |  |   |   | REG. NO. 16496  |   |  |
|---|--|----------------------|--|---|---|--|--|---|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>EMELINE E WOODS   |  |                      |  |   |   |  |  |   |   | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br>6 11 1981                              |   |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>CAUCASIAN |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>NOV 27, 1898                    |   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>87 YRS.  |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN                         |   | 2b. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>June 11 1981                          |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MASSACHUSETTS  |  |                      | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   |   | 8. MARRIED<br>WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY MD.  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>BETHESDA   |  |                      | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SUBURBAN |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE |   |   | 12b. KIND OF BUSINESS OR INDUSTRY   |   |  |
| 13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |                      |  |   |   |  |  |   |   |   |   |  |
| 13a. STATE<br>MARYLAND  |  |                      | 13b. COUNTY<br>MONTGOMERY  |   |   | 13c. CITY OR TOWN<br>BETHESDA  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br>4521 EAST WEST HIGHWAY |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>TERRENCE SWEENEY  |  |                      |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ANNA McNAMARA   |  |   |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>NO   |  |                      |  | 16b. SOCIAL SECURITY NO.<br>020-07-1937                               |   | 17. INFORMANT<br>DAUGHTER RUTH HILDEBRAND  |  |   | ADDRESS<br>4607 DAVIDSON DR. CHEVY CHASE, MD.   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>8147 IMMEDIATE CAUSE (a) Subdural Hematoma -<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) Fracture of Skull -<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Trauma - Pedestrian - Auto Accident.<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH            |  |                      |  |   |   |  |  |   |   |   |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                      |  |   |   |  |  |   |   |   |   |  |
| 19a. DATE OF OPERATION  |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                     |   |  |  |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                      |  | 21b. TIME OF INJURY<br>HOUR MIN. MONTH DAY YEAR<br>7:35 P.M. 6-5 1981 |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br>Struck by auto when crossing Street               |  |   |   |   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>  |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>Street |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>Lincoln + Old George Town Rd. Bethesda Mont. Md.                              |  |   |   |   |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                      |  |   |   |  |  |   |   |   |   |  |
| ACTUAL SIGNATURE<br>John G. Ball  |  |                      |  | TITLE (SPECIFY)<br>M.D. Deputy  |   |  |  | MEDICAL EXAMINER<br>DATE SIGNED<br>June 12, 1981                |   |   |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>JOHN G. BALL   |  |                      |  | ADDRESS<br>BETHESDA, MARYLAND   |   |  |  |   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  |                      | 23b. DATE<br>6/15/81   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>MT. CALVARY |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>EAST WOBURN MASS. |   |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>FRANCIS J. COLLINS  |  |                      |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>JUN 15 1981   |  | 25b. REGISTRAR'S SIGNATURE<br>Ruthy McBrady                     |   |   |   |  |
| 500 UNIV. BLVD., W. SILVER SPRING, MD. 20901  |  |                      |  |   |   |  |  |   |   |   |   |  |

